A Satyam Roychowdhury initiative

EXPRESSION OF SELF IN SCHIZOPHRENIA

This dissertation is submitted for the partial fulfilment for the degree of

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CERTIFICATE

This is to certify that the dissertation entitled "Expression of Self in Schizophrenia", submitted by Samiksha Bose, a 2nd-year M.Sc. student of Applied Psychology, Sister Nivedita University, is as bonafide work, which may be placed before the board of examiners for their evaluation. This is in partial fulfillment for the Degree of M.SC in Applied Psychology, Sister Nivedita University.

This is an original study done by the candidate and has not been submitted by her before any form for any other degree of this University or any other University.

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PLAGARISM CERTIFICATE

"I, SAMIKSHA BOSE, hereby declare that the research work titled " Expression of Self in Schizophrenia", which I have conducted, has been completed with full honesty and integrity. I confirm that the work is original, and all sources of information have been appropriately acknowledged and cited. I take full responsibility for the content and findings presented in this research."

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ABSTRACT

Schizophrenia Spectrum Disorder is a group of disorders with heterogeneous etiologies, varying clinical presentations, course of illness and treatment response. It is often referred to as a disorder of the self and is accompanied with disturbances in one's sense of self, resulting in a decreased self-concept clarity. Self-Concept Clarity (SCC) can be defined as the extent to which one's self-beliefs are clear, internally consistent, stable and cognitively accessible.

The present study focuses on understanding how an individual with Schizophrenia expresses or portrays themselves, for which the self-figure drawings of 40 individuals (20 individuals with Schizophrenia and 20 individuals without Schizophrenia) were recorded and analysed using the Draw-A-Person Test, followed by administration of the Self-Concept Clarity Scale.

The results showed that individuals with Schizophrenia have a significantly lower level of self-concept clarity than those without Schizophrenia. Decreased self-concept clarity affects an individual's expression of themselves and their experiences, thus, the present study helps us understand the personality characteristics, emotional functioning and other qualities of self and their response to others and their environment. The features that were commonly found in the self-figure of individuals with Schizophrenia included the placement of figures in the upper-left portion of the page, with an enlarged head, ears omitted, arms extended away and the frequent use of vertical lines. The frequently occurring qualities of an individual with Schizophrenia that were found, at least some features of which were found in the majority of the sample, if not all, included Schizophrenic tendencies, aggression, low energy, insecurity, rebelliousness, fantasy-seeking, low self-confidence, paranoia and regressive tendencies.

The knowledge and understanding of how an individual with Schizophrenia views and expresses themselves is vital in effectively developing interventions that suit them and their needs in their path to recovery. The main limitation of the study includes a small sample size of 40 individuals (20 individuals with Schizophrenia and 20 individuals without Schizophrenia), due to the availability of a limited period of time.

Keywords: Schizophrenia, Draw-A-Person Test, Self-concept clarity, Self-expression, Self

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CHAPTER 1

INTRODUCTION

Schizophrenia Spectrum Disorder is a group of disorders with heterogeneous etiologies with varying clinical representations, course of illness and treatment responses. It is often referred to as a disorder of self (Raffard et al., 2010; Parnas et al., 2011; Raffard et al., 2016; Mohamed et al., 2021; Nordgaard et al., 2021) that affects an individual's self-awareness, self-reflection and self-perception that alter the experience of self, thus affecting how they think, feel and behave (Raffard et al., 2010; Parnas et al., 2011; Mohamed et al., 2021).

Schizophrenia, being a disorder of the self, is not a new concept and is often brought up in all classic texts (Parnas & Zandersen, 2018). Many psychopathologists such as Kraepelin, Bleuler, Schneider, among others, have proposed the disturbed sense of self in Schizophrenia as the fundamental aspect of the disorder (Boulanger et al., 2013; Parnas & Henriksen, 2014; Nordgaard et al., 2021). The concept of disordered self in Schizophrenia is not new. Kraepelin, who had given the term "Dementia Praecox" to describe what we know today as Schizophrenia, had considered "disunity of consciousness" as a core feature of it (Sadock et al., 2015; Parnas & Henriksen, 2014; Nordgaard et al., 2021). Bleuler later, in 1911, described Dementia Praecox as an ego disorder which causes a disturbance/loss of self. He described it as "splitting of mind" where the loosening of associations results in incoherent thoughts and behaviours, which is a core symptom of Schizophrenia. He had also given the 4As of Schizophrenia: association, autism, affect and ambivalence, which today is thought to be an oversimplification of the symptoms of Schizophrenia (Sadock et al., 2015; Parnas & Henriksen, 2014; Parnas & Zandersen, 2018). Schneider, on the other hand, described Schizophrenia as a "radical qualitative change of the field of consciousness" which gives rise to the first-rank symptoms of Schizophrenia: audible thoughts, voices arguing, voices commenting, thought withdrawal, thought insertion, thought broadcasting, made volition, made affect, made impulse, somatic passivity, delusional perception (Sadock et al., 2015; Parnas & Henriksen, 2014; Nordgaard et al., 2021).

Today, according to the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders), Schizophrenia can be diagnosed by the presence of continuous signs of disturbance for at least 6 months, which may include prodromal or residual symptoms, and for at least 1 month of that period at least 2 of the following symptoms must be present, one of which is either

hallucinations, delusions or disorganised speech in addition to grossly disorganised or catatonic behaviour and negative symptoms. (American Psychiatric Association, 2013).

Schizophrenia can either emerge slowly over time or manifest abruptly as an acute short and intense episode. The first symptoms typically develop during adolescence or early adulthood. In some cases, the condition may progress into what is referred to as "chronic schizophrenia," which is a severe, long-lasting disability characterised by social withdrawal, lack of motivation, depression, and blunted feelings. (Sadock et al., 2015; Lev-Wiesel & Shvero, 2003; Parnas & Zandersen, 2018)

Research indicates alterations in the brain of an individual suffering from Schizophrenia. There is enlargement of cerebral ventricles, reduction of cortical volume, resulting in reduced volume of grey matter, abnormality in the pre-frontal cortex, reduced size of Amygdala and Hippocampus, which also functions abnormally, among others. There is also dysregulation of neurotransmitters, such as excess production of Dopamine and Serotonin (Sadock et al., 2015). As per the Neuro Anatomical Theory, there is structural impairment present in the inferior parietal cortex, which affects one's ability to regulate body image, sense of self, sensory integration and executive function. Abnormalities in grey matter which affect proprioceptive functions, resulting in failure to recognise oneself. Thus, these biological changes give rise to the symptoms presented in Schizophrenia (Mohamed et al., 2021)

It is often accompanied with symptoms such as sleep disturbance, disorientation, social withdrawal and isolation, somatic passivity, blunted affect, slowing of cognitive functions, unusual sensitivity to stimuli such as noise, unusual preoccupation with religion, different forms of disembodiment, altered existential pattern, deficit in emotional rapport, interpersonal difficulty, aggression, suspiciousness and fear. While none of these symptoms itself indicate Schizophrenia, they are often found in patients suffering from it (Lev-Wiesel & Shvero, 2003; Parnas & Henriksen, 2014). The symptoms of Schizophrenia were further divided by Schneider in to positive, negative and disorganized/catatonic symptoms. The positive symptoms are: hallucination and delusion. The negative symptoms are: alogia, anhedonia, avolition, affective flattening and apathy. While the disorganized/catatonic symptoms are: disorganized thought, disorganized speech, disorganized behaviour and disorganized emotion (Sadock et al., 2015). Based on this Andreasen and Olsen (1982) developed the criteria to divide Schizophrenia into 3 subtypes: positive, negative and mixed Schizophrenia. Positive schizophrenia is characterised by the prevalence of positive symptoms, negative schizophrenia is characterised by the

prevalence of negative symptoms and mixed schizophrenia is characterised by the prevalence of either both or neither of the positive and negative symptoms.

Common to all these symptoms is how it affects the self of the individual with the disorder. In fact, disturbance in perception of self is among the first symptoms of Schizophrenia to develop (Cicero et al., 2016; Ghosh & Muthukumaran, 2018). Self is the basis on which one experiences themselves and their surroundings. An individual has different selves for different situations and experiences (Cicero et al., 2016). They are experienced first-hand and are intrinsically bound together automatically with the pre-reflective immersion in the world (Nordgaard et al., 2021). Self can be said to have an intrinsic dichotomy between one's objective self-representation on a structural level and the subjective functional process of consciousness. This can be explained using the Theoretical Model of Self Duality by James (1980), which divides self into 2 categories: self as an object, i.e., "Me" and self as a subject, i.e., "I". "I" can be explained as the phenomenological conception of self. It guides and controls the subject's thoughts, experiences and behaviours, thus allowing one to assess themselves. It consists of the conscious recollection of past memories and imagination of future events due to autobiographical memories, as well as self-experience, which is the first-person perspective or experience of one's own internal states. "Me", on the other hand, focuses on the objective knowledge about oneself. It consists of self-knowledge involving traits, roles, beliefs, schemas, etc. and self-narratives that involve the salient experiences of an individual, such as self-defining memories (SDM) (Boulanger et al., 2013). Thus, resulting in the Core Self, which is the first-person perspective and is indispensable for any experience to be experienced, and for providing an immediate pre-reflective sense of subjectivity or "mineness". Thus providing structure for the Narrative Self to reflect upon. Narrative Self involves the features which individualizes an individual by objectively describe oneself. (Parnas & Henriksen, 2014; Parnas & Zandersen, 2018; Ghosh & Muthukumaran, 2018)

Generally, the sense of self persists over time and across various changing modalities of conscious life (Parnas & Henriksen, 2014). The sense of self of an individual develops via the interaction of the person with their environment bi-directionally, that is, depending on how one perceives and interprets their experiences, which leads to the formation of schemas or mental maps (Ghosh & Muthukumaran, 2018). However, individuals with Schizophrenia have a difficult time constructing a coherent sense of self by forming meaningful connections between their self and others or the world, which is generally a basic, automatic and non-reflective connection (Raffard et al., 2010; Parnas & Henriksen, 2014; Ghosh & Muthukumaran, 2018;

Nordgaard et al., 2021). The self-distortion and distortion in the boundary between oneself and others leads to structural instability of the self-world relation, which in turn leads to a disturbed sense of self (Ghosh & Muthukumaran, 2018; Parnas & Zandersen, 2018). Thought little is known about how the sense of self is constructed in individuals with Schizophrenia (Raffard et al., 2010).

A disturbed sense of self leads to a disturbed sense of unity and continuity, which causes impairments in self-awareness and self-reflection and alteration in the stream of consciousness, leading to disturbances in the fundamental features of personality (Raffard et al., 2010; Ghosh & Muthukumaran, 2018; Parnas & Zandersen, 2018; Nordgaard et al., 2021). Thus, individuals with Schizophrenia face persistent and profound alterations in their experience of self. This disturbance in self, also referred to as Anomalous Self Experience (ASE). Positive symptoms of Schizophrenia have a predictive role in Anomalous Self Experiences, which include cognitive impairment, depersonalization, de-alienation of self and distortion in the meaning-making process. These disturbances in self-experience are caused due to impairment in self-world boundary and boundary awareness between imagination and reality, which leads to symptoms such as auditory hallucination, thought insertion and delusions (Boulanger et al., 2013; Ghosh & Muthukumaran, 2018; Mohamed et al., 2021).

Individuals with Schizophrenia also have difficulty forming a coherent and consistent sense of self-identity. Identity is what allows an individual to know and understand oneself and be conscious of the differences with other people to feel unique. It can be said to be the told expression of self and is generally a stable set of continuous self-representations that are highly resistant to change. However, due to their disturbed sense of continuity in Schizophrenia, the continuity and consistency of one's sense of identity is diminished, fragmented or poorly elaborated (Raffard et al., 2010; Parnas et al., 2011; Boulanger et al., 2013).

This deviance in their innermost identity is accompanied with the feeling of being fundamentally different from others or even not completely existing (Parnas & Henriksen, 2014; Ghosh & Muthukumaran, 2018). For example, one person explained themselves as not feeling like a spiritual being but rather a physical object such as a heater, while another expressed themself to be akin to a robot, without a soul (Raffard et al., 2016). Thus, many aspects of self are alienated and not perceived as part of the self-leading many of the symptoms in Schizophrenia (Ghosh & Muthukumaran, 2018). The Ipseity or the pre-reflective identification that all the lived experiences of an individual are their experiences, that is, from

a first-person point of view is distorted, resulting in alterations of "I think" transforming to "It thinks in me". This sense of alienation of self-consciousness, where it is not perceived as a part of self, is a constant part of the individual's conscious life (Parnas & Henriksen, 2014; Ghosh & Muthukumaran, 2018).

The identity distortion primarily affects two complementary domains: self-affection and hyper-reflexibility. Self-affection or a sense of "mineness" is diminished, causing a reduction of the feeling of complete sense of awareness wherein the implicit aspects of self are diminished, thus alienating parts of self. This can be manifested in the alteration of thoughts, such as "I think" changing to "it thinks in me." Hyper-reflexibility is a reduction in feeling privy to one's inner experiences while being hyper-conscious of certain implicit aspects of self, resulting in their thoughts and feelings being regarded from afar instead of being lived through them (Cicero et al., 2016; Raffard et al., 2016; Ghosh & Muthukumaran, 2018; Parnas & Zandersen, 2018).

The experience of self is closely related to one's ability to remember their past and to be able to project or imagine themselves into the future and simulate experiences that might occur. Schizophrenia impairs one's ability to make meaning of past experiences, interpret and understand situations and construct future scenarios and goals, due to an affected sense of continuity (Raffard et al., 2016; Ghosh & Muthukumaran, 2018). Research showed that individuals with Schizophrenia generate fewer memories, have difficulty in accessing autobiographical memories and have trouble recalling events at a particular time and place. However, they tend to recall more public events than private or personal ones. Reasoning with autobiographical memories and personal events forms self-event connections, which foster personal growth and self-coherence across time. To maintain a continuous and stable sense of self across time, not only is the retrieval of specific past events required, but also the ability to create coherent links between oneself and past experiences. However, extracting meaning from memories is hampered, resulting in the meaning-making process being severely impaired in Schizophrenia. (Raffard et al., 2010; Boulanger et al., 2013; Raffard et al., 2016)

It has also been found that individuals with Schizophrenia recalled as many self-defining memories (SDM) as the healthy control group. Self-defining memories are those that help define how one sees themselves and explain oneself to others. They generally evoke strong emotions when recalled and are linked to other meaningful memories, and are critical in developing and maintaining a stable sense of self. Even though individuals with Schizophrenia recalled as many SDMs, the temporal distribution of the memories shifted towards an earlier

life period of approximately 15-19 years of age compared to 20-24 years of the control group, which is the time when the first symptoms of Schizophrenia start to develop (Raffard et al., 2010; Raffard et al., 2016). Though there was seen to be little connection between SDMs and their objective self-knowledge (Boulanger et al., 2013). Additionally, the thematic content of the self-defining memories also differed from the control group. Individuals with Schizophrenia tend to recall fewer memories about achievement and relationships and more memories about life-threatening events, stigmatisation and hospitalisation. In fact, memories about the stigmatisation and hospitalisation are seen to be more prevalent. They focus on abstract memories to define their self. This may be due to disruption in life due to the onset and course of illness, along with early psychological abnormalities present before the onset of the disorder during the prodromal phase. This increases the instances of social withdrawal and isolation in individuals, thus decreasing the opportunities to make many positive memories about achievements and relationships. (Raffard et al., 2010; Raffard et al., 2016)

Individuals with Schizophrenia are often hospitalised when their symptoms are deemed to be unmanageable by the family. Long-term hospitalisation often has adverse effects regarding the patient's self-perception, self-stigma and adjustment in society (Kanchan et al., 2010; Ghosh & Muthukumaran, 2018). Even before a patient is admitted to the hospital, they face the stigma of society and often their family members. Individuals with Schizophrenia often see the symptoms as a part of themselves and so are not disturbed by them, but the societal rejection and feeling of being abandoned and being "dumped" in the hospital cause more distress than the symptoms of Schizophrenia themselves (Ghosh & Muthukumaran, 2018). This causes a lack of motivation, self-stigmatisation and negative self-concept in patients. The lack of interaction with the external environment and detachment from society, especially for long-term hospitalisations, further pushes them to engage in their inner world and often compensate for it with fantasy activity. This, in turn, impairs their development and causes regression, resulting in a global social deficit. (Kanchan et al., 2010)

The institutionalisation further has different effects on males and females. Males, culturally, are more expressive of their sexual needs and desires. As a result of the confinement of a male to only the environment in hospital and the anti-psychotic drugs given for treatment, which deprive their basic sexual drives, causing a sexual conflict within them, as seen in Jharkhand via the drawings of naked figures without genitals. Females, on the other hand, are culturally less sexually preoccupied, thus, they have sexual desires that they can't express indicated via the naked figures with genitals drawn. Additionally, females have greater social conformity

and being nurturers, often define their sense of self through their feelings and relationships with others yet they are more often “dumped” in hospitals when they become difficult to handle and face more reluctance in taking them back, they develop a sense of insecurity, lack of confidence and helplessness. (Kanchan et al., 2010)

These, in turn, affect the self-concept of an individual. Self-concept can be defined as the collection of beliefs that an individual knows and holds about themselves, in terms of which they think about, evaluate and perceive themselves. Self-concept can be divided into 2 main categories: positive self-concept and negative self-concept. Positive self-concept: recognising one’s assets and potential while being aware of their limitations, helping them cope with challenges. Negative self-concept: focuses on one's faults and weaknesses, which leads to a lack of self-confidence during situations. Disturbances in self-concept is common due to difficulties in maintaining interactions among the different selves as well as the self-world boundary. Thus, resulting in a lack of self-concept clarity.

Self-Concept Clarity (SCC) can be defined as the extent to which one’s self-beliefs are clear, internally consistent, stable and cognitively accessible. This is often presented in the form of a lack of coherent self-narrative. (Cicero et al., 2016). Phenomenological research indicates that disruptions in self-concept clarity may be a core phenotypic marker of Schizophrenia (Mohamed et al., 2021). Decreased self-concept clarity in Schizophrenia may be attributed to three domains: 1. Somatosensation and body perception, which includes the sense of touch, proprioception, and general perceptions regarding one’s body; 2. Phenomenological self-experiences, which involve the first-person experiences of body ownership and integrity; and 3. Dialogical self, which can be said to be the ability to converge the many aspects of self-concept into a coherent identity (Mohamed et al., 2021).

Knowledge and understanding about the etiology and progress of the disorder and treatment helps improve self-concept clarity as it fosters self-understanding. This also affects an individual’s quality of life. Higher self-concept clarity in Schizophrenia may be regarded as a risk more than resilience, as it increases focus towards oneself leading to excessive processing of internal cues affecting the hyper-reflexibility/self-monitoring. (Ghosh & Muthukumaran, 2018) Generally the awareness of distortions in Schizophrenia is low, resulting in lower insight. Infact, the symptoms or distortions are not seen as problematic aspects that need to be sorted, but rather as a part of their reality or existence, how they express themselves, view others and the world. (Parnas & Henriksen, 2014; Ghosh & Muthukumaran, 2018)

It is important to understand how an individual with Schizophrenia views and understands themselves, others and the world they live in, in order to effectively develop interventions that suit them and their needs in the path to recovery. Understanding the effects of stigmatisation and hospitalisation on their self-concept and self-concept clarity will help us devise interventions to improve their insight and foster recovery without compromising their quality of life.

Often, projective tests are used in research for Schizophrenia Spectrum Disorder alongside quantitative scales. Schizophrenia, being a spectrum disorder, is often too vague and heterogeneous to be assessed adequately using structured questionnaires. So many use semi-structured interviews as a method; however, with a vastly different sense of subjectivity along with poor communication ability, information is not always verbalised precisely. Projective tests are therefore suitable to elicit information that the individual may not be fully aware of or even willing to verbalise, as symbolic expressions of the unconscious mind. There are also many non-verbal aspects to self which can be studied using this method. (Kanchan et al., 2010; Parnas & Henriksen, 2014; Ghosh & Muthukumaran, 2018)

The Draw-A-Person Test is a common projective test administered to individuals with Schizophrenia. It is suitable for individuals with poor communication abilities, as it does not require verbal behaviour. (Kanchan et al., 2010) Over the past decade, the number of studies on self-concept clarity in Schizophrenia has increased, however, studies on this topic in India remain limited. On the other hand, research on Schizophrenia using the Draw-A-Person Test has been few and far apart in the last 15 years, often focusing on a particular aspect of personality or functioning. Additionally, to my knowledge, there hasn't been a study examining whether self-concept clarity in Schizophrenia influences results in the Draw-A-Person Test. This study seeks to bridge these gaps.

CHAPTER 2

LITERATURE REVIEW

The study done by **Lev-Wiesel & Shvero (2003)** focused on features in self-figure drawings of individuals with Schizophrenia that indicate anxiety, aggression, visual or auditory impairments which are expressed in hallucinations, disorganization, and reality distortion. For this they had a sample of 30 participants diagnosed with Schizophrenia, along with a control group of 30 individuals without Schizophrenia, on whom the Draw-A-Person Test was administered and the features studied were rated on a 4-point Likert Scale by 2 social workers, who were also art therapists. The results showed that the self-figure drawings by individuals with and without Schizophrenia differed significantly. They found body line, ears, eyes, head line, head size and missing body parts to be common indicators of aggression. Additionally, the results indicated that 36% of an individual's Schizophrenia could be predicted by the indicators in their self-figure drawings, thus, the Draw-A-Person Test could be used as for analysis and therapeutic purposes but not to predict Schizophrenia. The limitations of the study included a small sample, with most of the participants having Paranoid and Residual type of Schizophrenia, along with heterogeneity within the sample.

The investigation carried out by **Kumar et al. (2004)**, compared the human figure drawings of individuals with Schizophrenia, Mania/Manic Disorder and the control group, on a sample consisting of 28 individuals with Schizophrenia, 25 individuals with Mania and 30 individuals without any psychological disorder, of both gender between the age of 20-25 years. The Draw-A-Person Test was administered where each participant drew only 1 figure. The drawings were analysed both qualitatively and quantitatively. The results highlighted that individuals with Schizophrenia had a higher percentage of omission of nose, nostril, chin, hands, fingers, trunk, dress, legs, feet, and toes, emphasis of hairs, eyes and eyebrow, along with features of genitals showing, angular trunk, and confusion of face.

The study done by **Kanchan et al. (2010)**, was designed to use the Human Figure Drawing Test as a means of self-expression in Schizophrenia and compare drawing patterns between male and female respondents. The sample consisted of 50 males and 50 females with Schizophrenia and 50 respondents without Schizophrenia as the control group. The Brief Psychiatric Rating Scale and the General Health Questionnaire-12 were used to identify and exclude respondents. The results implied a significant cognitive impairment in individuals with Schizophrenia compared to the control group, though the difference between males and females

with Schizophrenia was not significant. Individuals with Schizophrenia commonly drew on the upper-left portion of the page, which indicates that the individual seeks satisfaction in fantasy, is aloof and has high aspirations with low energy level. Additionally, the figures were small in size showing feelings of inferiority and inadequacy, were genderless indicating that they have a tendency to withdraw, regress and have negative self-concept. Individuals had omitted neck, shoulders, trunk, arms, hands, pupil and mouth indicating presence of immaturity, egocentricity and regression. The figures also had spiked fingers indicating aggression.

When compared between males and females, it was seen that females tend to draw more bizarre drawings, indicating thought disorder and organicity, along with frequent omission of shoulders, arms and fingers and drew more angular or squared trunks, while males drew figures closer to the edges and were more tremulous. While both tended to draw naked figures, males drew naked figures without sex organs (often for female drawings), while females drew naked figures with genitals. The tremulous figures in males indicate schizoid traits or alcoholism, which is more common in males than females, attributed to cultural factors of Jharkhand, where the study was done. It is also consistent with the findings of similar studies done previously. While in females, omission of shoulders, hands and fingers indicates feelings of inferiority, inadequacy, helplessness, regression and lack of confidence, which is consistent with past studies. However, omission of feet, which was found to be significant, is inconsistent with past studies, which indicate emphasis of feet. Naked figures without genitals drawn by males indicate narcissism and inattention to details associated with denial or sexual conflict, while naked figures with genitals drawn by females indicate impulsivity and erotic desire.

While the study done by **Iqbal et al. in 2013** focused on the drawing features of individuals with Schizophrenia using the Draw-A-Person Test to test whether specific emotional indicators can be used as diagnostic indicators. They had a sample of 200 individuals with Schizophrenia and 200 without it, both males and females, between the ages of 20 to 50 years. The results found 9 exclusive emotional indicators and 4 frequent differentiating emotional indicators can be significant diagnostic drawing signs for Schizophrenia, thus the Draw-A-Person test can be used as a diagnostic tool for schizophrenia with a battery of other psychological tests.

The 4 frequent differentiating emotional indicators are poor integration indication organicity or mental retardation, gross disproportion which reflect physical awkwardness, inadequacy or confusion of lateral dominance, grotesque figures which are associated with feelings of inadequacy and poor self-concept and vacant eyes which reflect a vague view of the world,

emotional immaturity, dependency, a lack of discrimination or depression. The 9 exclusive emotional indicators are omission of body, nose, eyes, dot eyes, presence of genitals indicating pathology, shading of hands and neck, large ears indicating paranoia, joint emphasis and broken lines. The limitations of the study included the selection of the sample being done on the basis of levels of age and not considering factors such as gender, educational background and socioeconomic status.

The study by **Zhou et al. (2019)** explored the difference in performance between individuals with Schizophrenia with primarily positive symptoms and primarily negative symptoms in the Synthetic House-Tree-Person Test. They had a sample of 58 participants with Schizophrenia, between the ages of 16-55 years. The tests used were the Synthetic House-Tree-Person Test, along with the Scale for the Assessment of Negative Symptoms and Scale for Assessment of Positive Symptoms.

The results showed features such as inappropriate size, usually large, oblique eyes, thin and limp arms, and big hands were commonly present in Schizophrenia. Weak limp arms indicate weak inner spirit and a lack of mental energy, while a larger figure indicates extrovertedness and a tendency to attack. Positive Schizophrenia tends to have features of large size, oblique eyes and big hands commonly. They are generally more expressive, impulsive, aggressive and fantasy seeking. While Negative Schizophrenia tends to have omissions of some body parts and weak, limp and shrunken arms. They tend to lack interest in social interactions and avoid social situations, along with the presence of a weak will. It is important to note that these features are not exclusive to one type or the other; omission of some body parts can also be seen in patients with hallucinations and delusions, and large size can also be present in individuals with anhedonia and attentional impairment.

Parnas & Zandersen (2018) has contributed with a review article focusing on Schizophrenia and self in Schizophrenia. They elaborated with secondary data collected from various sources explaining how self and identity in Schizophrenia work, the nature of disturbed self in Schizophrenia and how it has been explained in the past.

The study done by **Raffard et al. (2010)** examined the narrative identity of individuals with Schizophrenia via self-defining memories. The study included a sample of 81 individuals with Schizophrenia and 50 individuals without Schizophrenia as the control group. The tests involved were self-defining memories (SDMs) questionnaire and the Positive and Negative Affective States (PANAS).

The findings revealed that the narratives of patients were less coherent and detailed compared to those of the control group. Individuals with schizophrenia showed significant difficulties in linking experiences to their sense of self and deriving meaning from their memories, which was notably associated with the duration of the illness. They also demonstrated an earlier reminiscence bump than the control. Furthermore, the era of the reminiscence bump, which is crucial for identity formation, was marked by fewer accomplishments and a higher frequency of life-threatening events in comparison to controls. A negative association was observed between negative symptoms, the number of self-event connections, and the specificity of their narratives. The findings indicate that patients with schizophrenia struggle to organise and find meaning in their past experiences, hindering the formation of coherent personal narratives. The limitations of the study included not checking whether the memories of individuals with Schizophrenia were consistent and corroborative with their family and friends. Also, the limited scope of the study, as more aspects of life in addition to the self-defining memories explored, can have an effect on the formation of identity of an individual.

The study done by **Parnas et al. (2011)** is the 5-year follow-up study of the Copenhagen Schizophrenia Prodromal Study, which focuses on the self-experience of an individual with Schizophrenia during the early phases on the disorder. They explained how the experience of self is altered in individuals with Schizophrenia and how this instability in the sense of self changes with the progression of the disorder. The sample consisted of 151 patients, when they were first admitted 5 years prior, with ages older than 40 years. The scales used were the Bonn Scale for the Assessment of Basic Symptoms (BSABS), the Positive and Negative Syndrome Scale (PANSS), and the DSM-III-R Severity of Psychosocial Stressors Scale: Adults. The results showed that the rate of conversion to schizophrenia spectrum diagnosis was 37%, whereas the conversion rate from schizotypal disorder to schizophrenia was 25%, as well as the escalating transitions within the spectrum (i.e., from schizotypal disorder to schizophrenia) were not associated to any candidate psychopathological predictor.

The research conducted by **Boulanger et al. (2013)** explores the disturbance in identity in Schizophrenia, along with its effects on the representations about oneself and a phenomenological self. It investigates the stability and the quality of traits self-knowledge, a component of abstracted representations of self, in schizophrenia patients. The sample consisted of 68 individuals with Schizophrenia and 68 individuals without Schizophrenia. The short version of the LABEL (Liste d'Adjectifs Bipolaires et Echelle de Likert) scale was used to evaluate the stability of identity. The results indicated that the identity of individuals was

unstable as well as different in quality compared to the control group. Along with the small identity disturbance with poor stability, the knowledge about identity traits was uncertain and undefined, with definition of self-lacking in coherence.

The work by **Parnas & Henriksen (2014)** focuses on the disorder of self in Schizophrenia. It explores the phenomenological and empirical effects of anomalous self-experience as a core feature of Schizophrenia and presents the current status of research in this topic. It is a review article, where they summarise empirical studies focusing on self-experience in Schizophrenia done prior to and after the construction of a phenomenologically oriented psychometric instrument for assessing anomalies of self-experience, the Examination of Anomalous Self-Experience (EASE). They further discuss the effectiveness of the use of this scale in research.

The study by **Raffard et al. (2016)** explores individuals' ability to project themselves into the future in a cross-sectional study consisting of 27 and 26 individuals with and without Schizophrenia, respectively. The ability to project oneself into the future contributes to the development and maintenance of a coherent sense of identity or self. Data was collected via a structured clinical interview based on the Structured Clinical Interview for DSM-IV Axis I Disorders (SCID-1). The results highlighted that individuals with Schizophrenia had difficulties in reflecting on the broader meaning and implications of imagined future events. The results also suggested that Schizophrenia patients have an exaggerated positive perception of their future selves.

The work done by **Nordgaard et al. (2021)** deals with disordered self in individuals with Schizophrenia, with a focus on the psychometric test Examination of Anomalous Self-Experience (EASE). This review article outlines the historical context surrounding the development of the EASE, clarifies the concept of the disorder of basic or minimal self through phenomenological philosophy, and offers a concise overview of the clinical symptoms addressed by the EASE. They conclude that the basic self-disorder represents a crucial phenotype of Schizophrenia, which offers a potential avenue to empirical pathogenetic research and psychotherapeutic treatment.

While **Ghosh & Muthukumaran (2018)** also contributed with a review article, focusing on the disturbances of self in Schizophrenia, current advancements in research regarding it, critical issues surrounding it and future directions that can be taken based on clinical applications. They conducted a systematic review of literature, focusing on studies where primary data has been collected using different scales and methods to measure different aspects of self, such as

minimally prompted self-descriptions, qualitative narratives, The Assessment of Self Descriptions Manual, Examination of Anomalous World Experience, rather than just examination of Anomalous Self-Experience (EASE), Inventory of Psychotic-Like Anomalous Self-Experiences (IPASE), Self-Esteem Scale, Self-Concept Clarity Scale and "self is ill" subscale of Personal Beliefs about Illness Questionnaire.

They elaborated on the difficulties of research on Schizophrenia, how the sense of self of an individual with Schizophrenia is affected due to anomalous self-experiences, which is common in psychosis, how different factors such as hospitalisation and stigmatisation affect self-concept clarity and quality of life of an individual with Schizophrenia, thus affecting their recovery process. They further explain the limitations of the Self-Concept Clarity Scale, in the clarity or subjective interpretation of certain items, leading to a black and white interpretation of the items.

The study done by **Cicero et al. (2016)** explored the self-concept clarity of individuals diagnosed with Schizophrenia, as well as the difference in self-concept clarity based on positive and negative symptoms of Schizophrenia. The sample included 54 individuals with Schizophrenia and 32 individuals without any psychological disorder as the control group. They were tested using the Self-Concept Clarity Scale, Me Not-Me Decision Task (MNMDT), Cardiff Anomalous Perceptions Scale (CAPS), Peters Delusion Inventory (PDI), Revised Social Anhedonia Scale (RSAS), Physical Anhedonia Scale (PhysAnh), as well as the Mini-Mental Status Exam (MMSE). The results indicated that individuals with Schizophrenia had a lower self-concept clarity than those without. Both positive and negative Schizophrenia had correlated negatively with self-concept clarity, though positive Schizophrenia were more strongly associated with it than negative Schizophrenia. A limitation of the study was due to the differential item functioning (DIF) of the Self-Concept Clarity Scale items had not been tested, which may make the comparison between groups invalid since the scores may have different meanings in the different groups.

The study by **Mohamed et al. (2021)** explored the relationship between self-concept clarity and individuals with Schizophrenia, specifically Positive and Negative Schizophrenia. The sample consisted of 200 individuals with Schizophrenia, who were assessed using the Brief Psychiatric Rating Scale (BPRS-version 4.0) and the Self-Concept Clarity Scale. The results revealed that individuals with Schizophrenia had low self-concept clarity, with 50.5% of the studied sample demonstrated low self-concept clarity, while 38.5% of the sample had moderate

self-concept clarity. Additionally, statistically significant correlations were found between self-concept clarity in relation to positive and negative symptoms of Schizophrenia. Self-concept clarity was partially influenced by duration and course of illness.

CHAPTER 3

METHOD

Objectives

To explore the characteristics of self-representation and the differences in personality characteristics, emotional functioning and self-concept between individuals with and without Schizophrenia. To explore the relationship between the quality of self-representation and self-concept clarity in individuals with and without Schizophrenia

- To determine the self-concept clarity of individuals with and without Schizophrenia
- To assess the influence of hospitalisation on self-concept clarity in individuals with Schizophrenia
- To explore the influence of gender differences on self-concept clarity in individuals with Schizophrenia
- To explore the influence of gender differences on self-concept clarity in individuals without Schizophrenia

Hypothesis

- H_{01}: There will be no significant difference in self-concept clarity between individuals with and without Schizophrenia
- H_{02}: There will be no significant difference in self-concept clarity between individuals who have and have not been hospitalised
- H_{03}: There will be no significant difference in self-concept clarity between males and females with Schizophrenia
- H_{04}: There will be no significant difference in self-concept clarity between males and females without Schizophrenia

Sample

The sample consisted of 20 participants with Schizophrenia (medically diagnosed with Schizophrenia) and 20 normally functioning participants (not diagnosed with Schizophrenia). Both males and females, of the age group 18 to 60 years.

Sampling Procedure

Purposive Sampling was used to choose the sample, based on the particular characteristics of the population that are of interest, to fulfil the research objectives. In this method, the sample is chosen based on the judgment of the researcher, with the intention to make generalisations or statistical inferences

Inclusion and Exclusion Criteria

Group 1 (with Schizophrenia):

- males and females within the age range of 18-60 years
- medically diagnosed with Schizophrenia (any type)
- without any other comorbid psychological disorders.

Group 2 (without Schizophrenia):

- males and females within the age range of 18-60 years
- not diagnosed with any psychological condition.

Tools to be Used

Draw-A-Person (DAP) Test: is a projective test based on drawing a human figure, which is a universal figure. It is based on the idea that the figure drawn represents the subject, while the paper represents their environment. It was first developed by Goodenough in 1926 for children, which was later expanded for adolescents and adults by Machover in 1949. DAP is suitable for individuals with poor communication abilities, as it does not require verbal behavior. It is used by those who are interested in the assessment of the personality dynamics of children and adults, deaf and dumb, those who speak a different language or come from different cultures. The human figure drawing has been interpreted on the basis of variation in characteristics such as size, placement on the page, apparent rigidity of the drawn figure, drawing proportion, aesthetic appearance, line quality, gender issues, clothing, omission, etc. It has a .99 inter-rater reliability (Gonzales, 1982) and a validity of correlation of 0.74 was obtained between the Stanford Binet IQ scores and DAP (Test).

Self-Concept Clarity Scale (SCCS): developed by Campbell et al. in 1996, is a 12 item scale designed to determine the extent to which self-beliefs are clearly and confidently defined, internally consistent and stable. It assesses the perceived internal consistency and temporal stability of self-beliefs, along with more generic self-certainty items. Items are rated on a 5-point Likert Scale that ranges from 1 (strongly disagree) to 5 (strongly agree). The total score ranges from 12 to 60, with a higher score indicating higher self-concept clarity in individuals. It has a reliability of 0.86 and a good external validity.

Procedure

The group 1 data, that is for individuals with Schizophrenia, was collected from the Pavlov Hospital, Kolkata. The purpose of the study was explained to the participants (both groups 1 and 2), and their consent was taken. Mental Status Examination of group 1 participants was taken, and it was ensured that their intelligence was average. They were then provided with an A4, a pencil and an eraser. Each participant was required to draw only one figure, followed by the Self-Concept Clarity Scale.

For the Draw-A-Person Test, only 1 phase was conducted, that is, the self-drawing phase, as it focuses on the self of an individual, thus aligning with the aim of the study.

Participants who failed to draw a human figure and those with other comorbid psychological disorders were excluded from the study.

The Draw-A-Person Test was evaluated by the researcher, and an experienced clinical psychologist was consulted, according to the manual by the Department of Psychiatry, Postgraduate Institute of Medical Education and Research and the manual by Goodenough. It was then qualitatively analysed. The Self-Concept Clarity Scale, on the other hand, was analysed quantitatively.

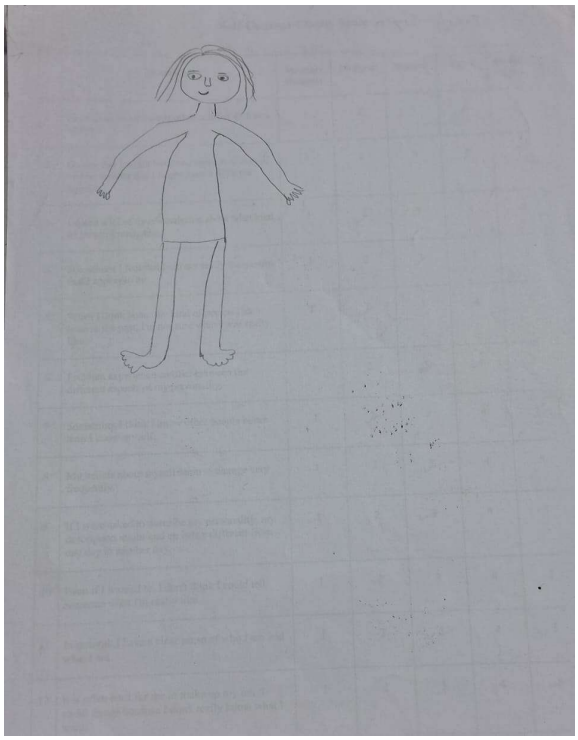
Analysis of Data

The data was analysed using Jamovi software. The statistical package was used for the Descriptive Statistics of the self-concept clarity scores of the sample, to check the normality and assumptions and further perform T-Test to find the difference between groups of sample.

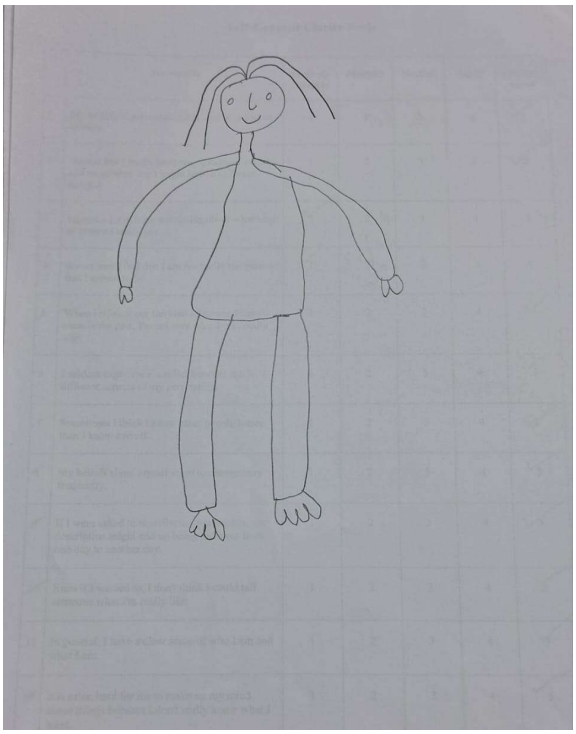
CHAPTER 4

RESULTS

Self-Figure Drawings of Group 1



Self-figure drawing in Schizophrenia (S1)



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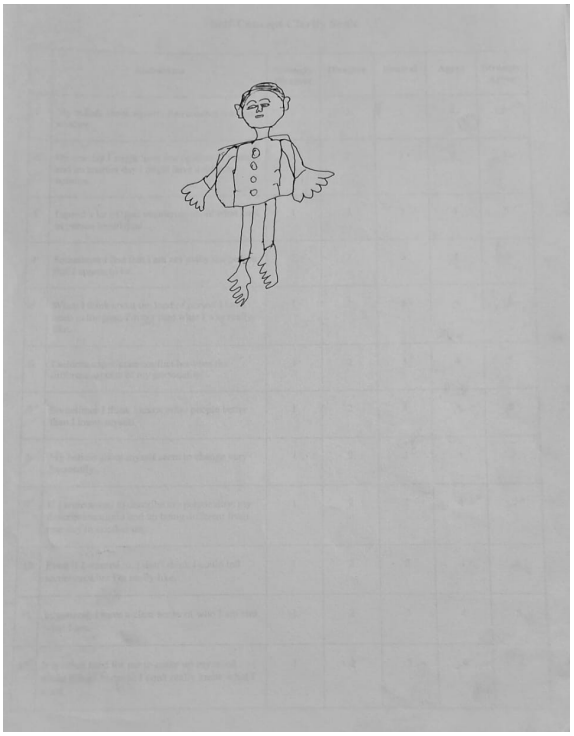

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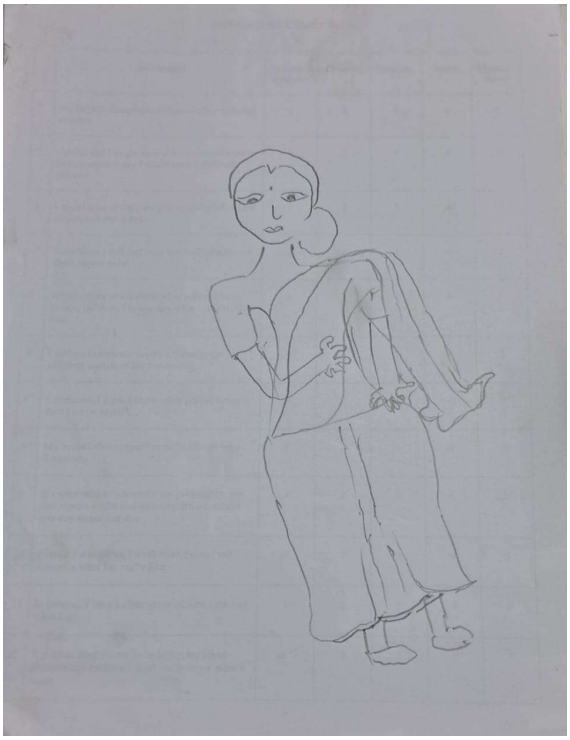

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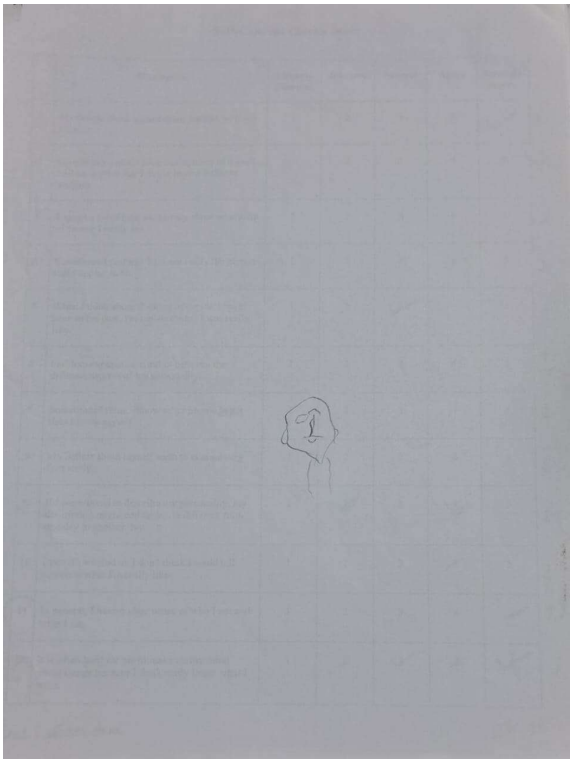

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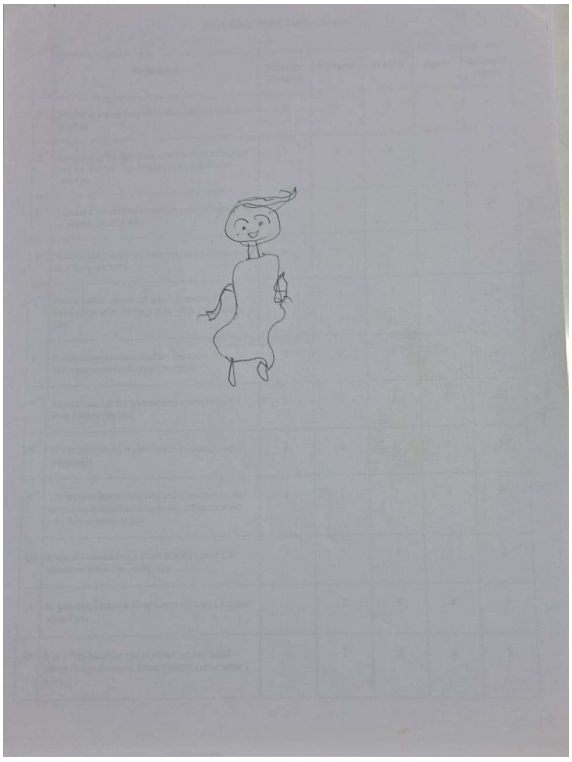

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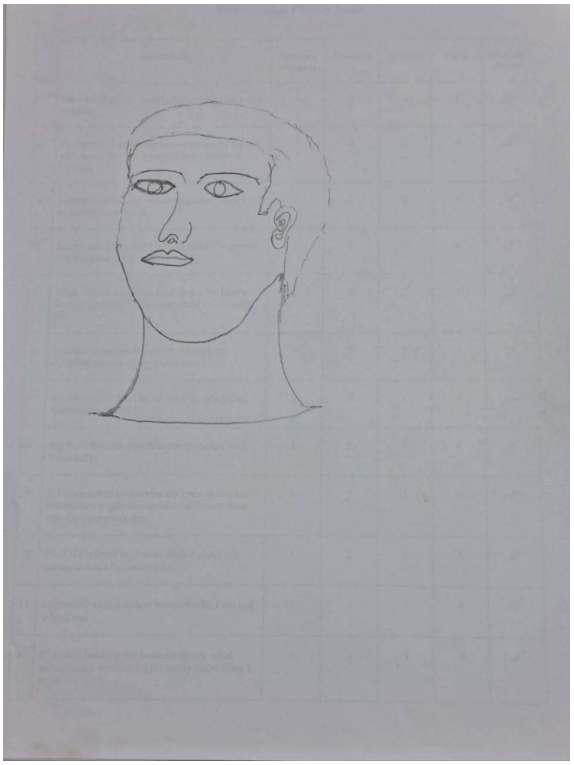

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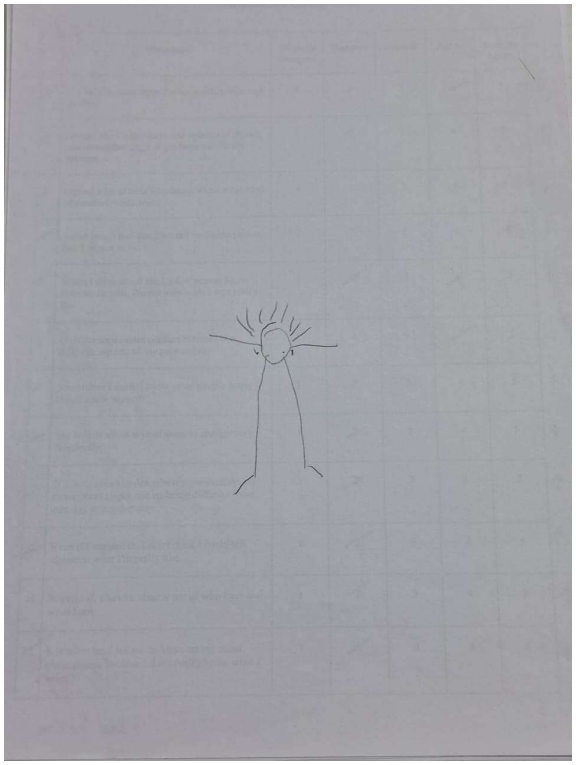

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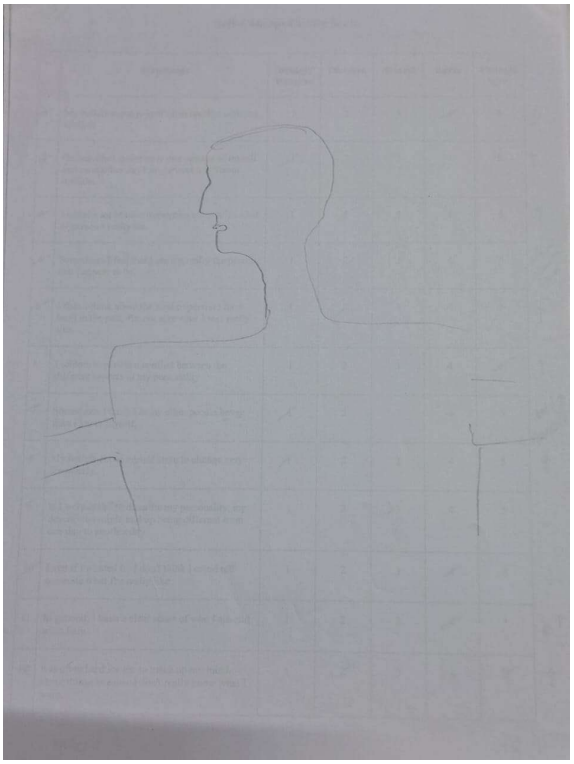

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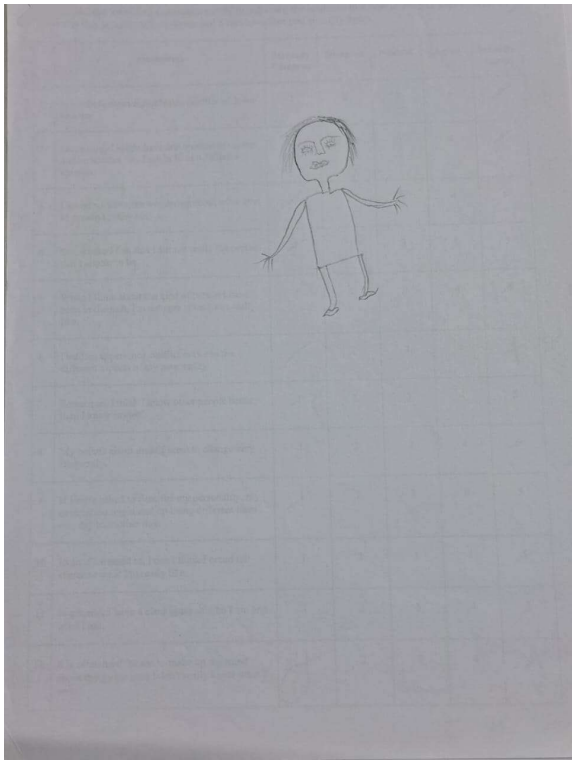

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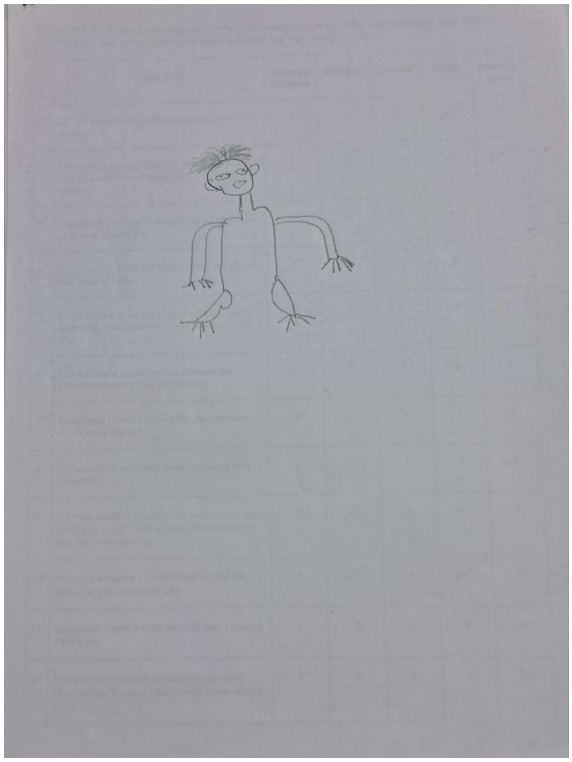

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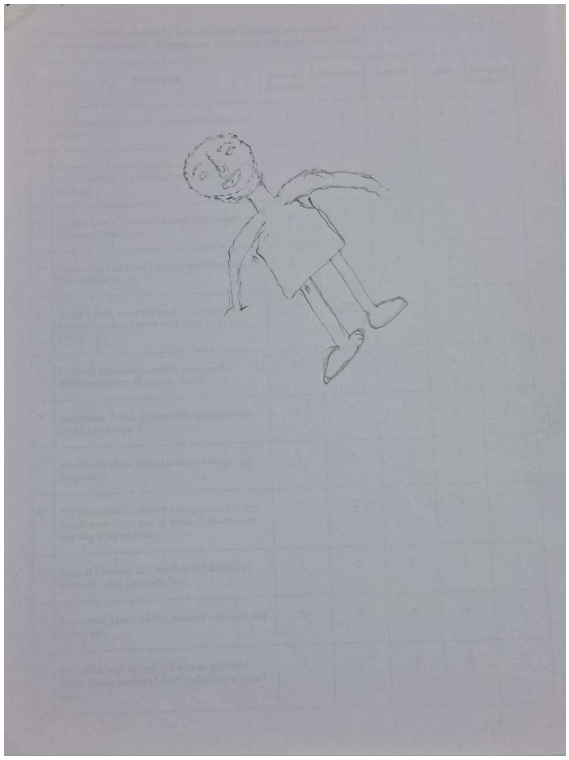

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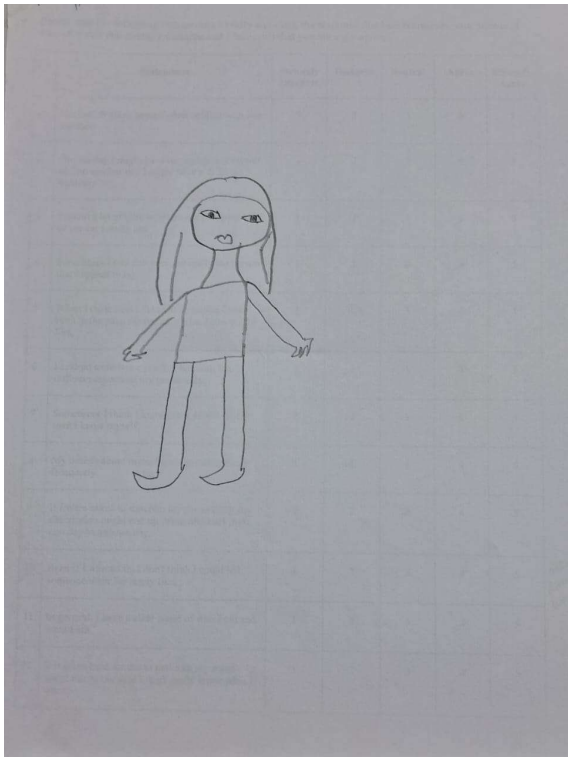

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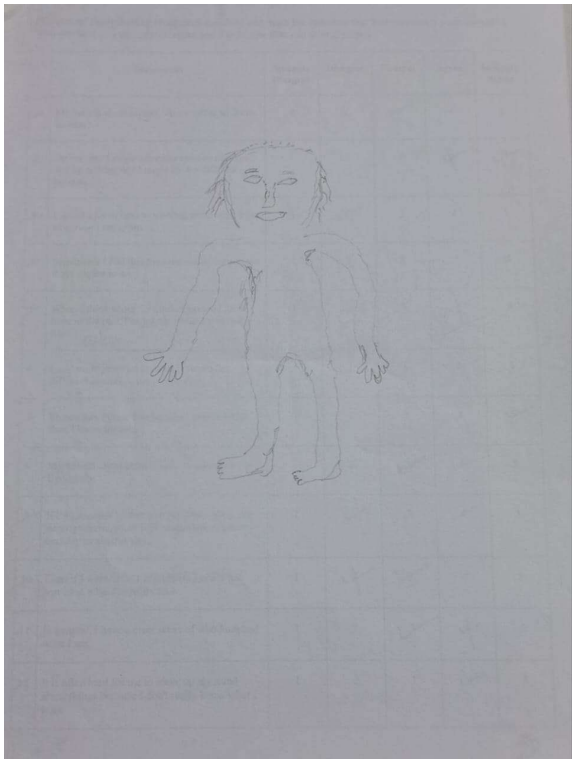

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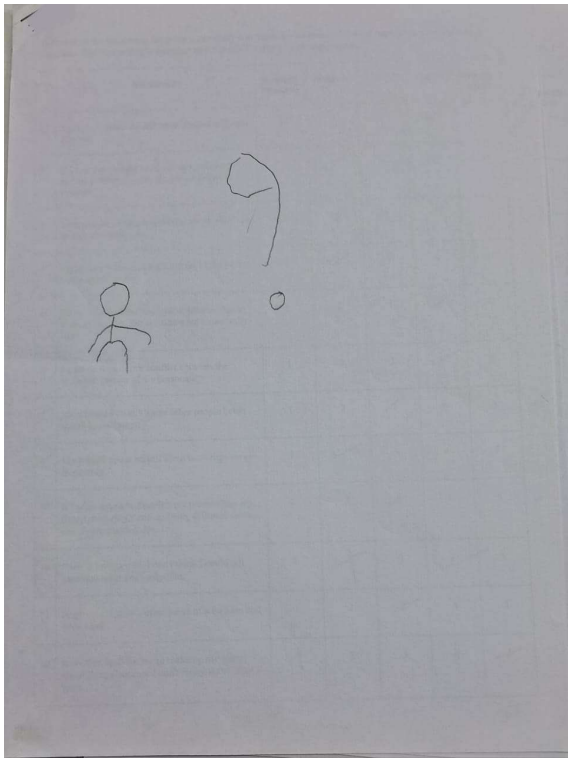

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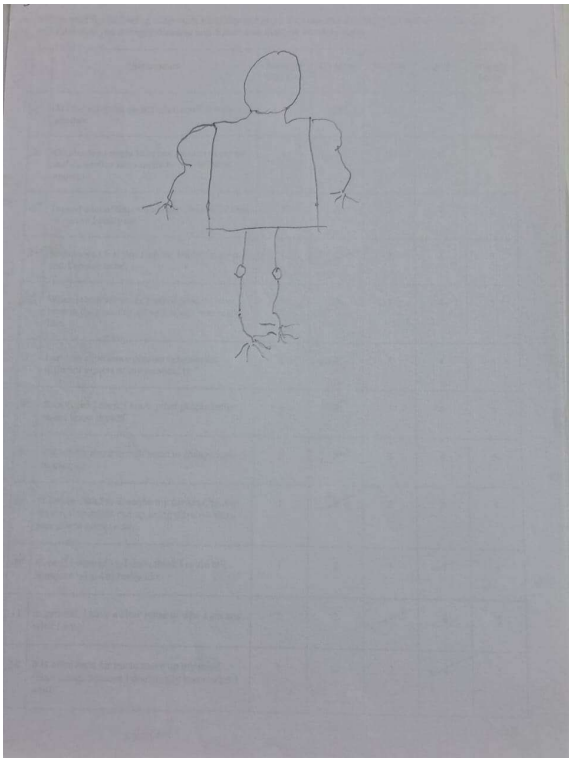

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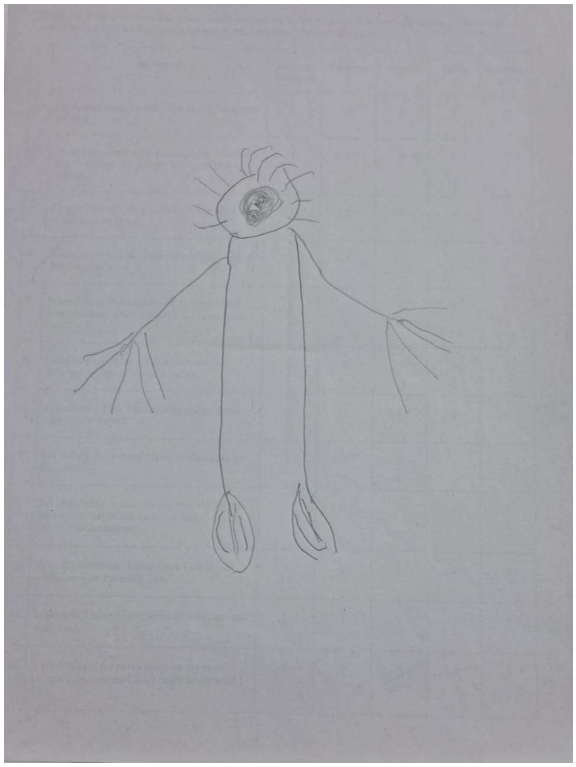

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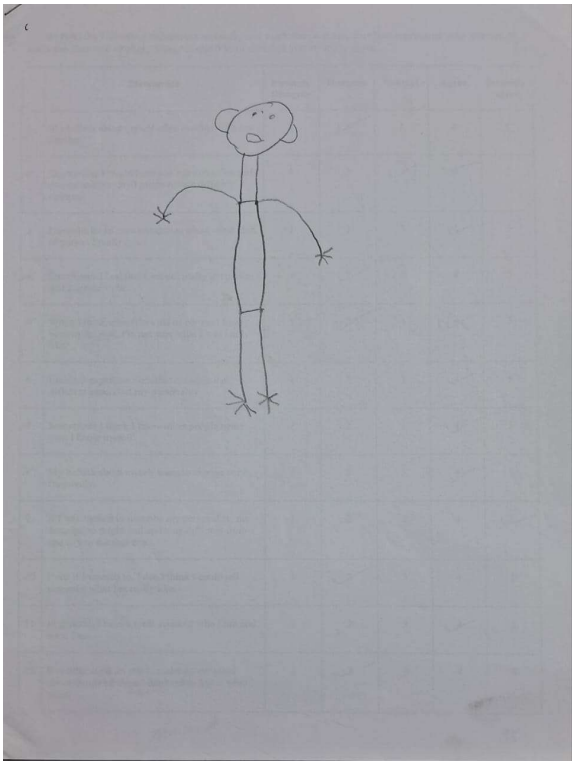

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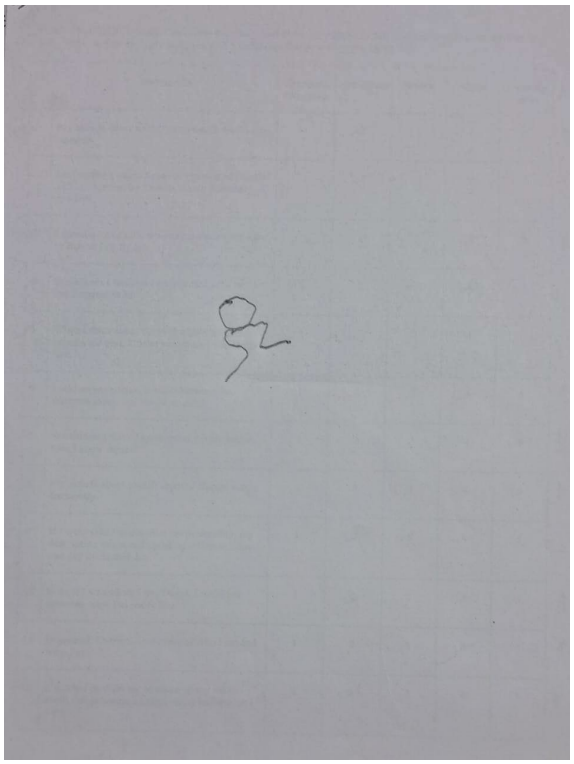

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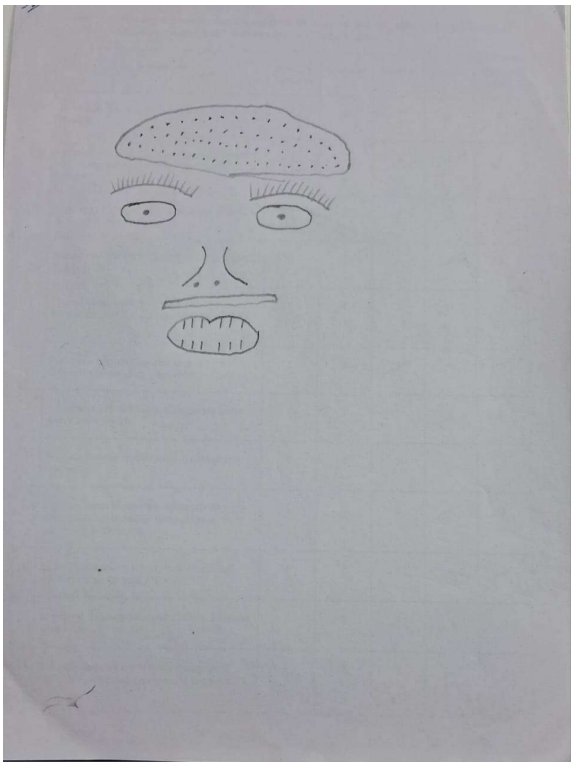
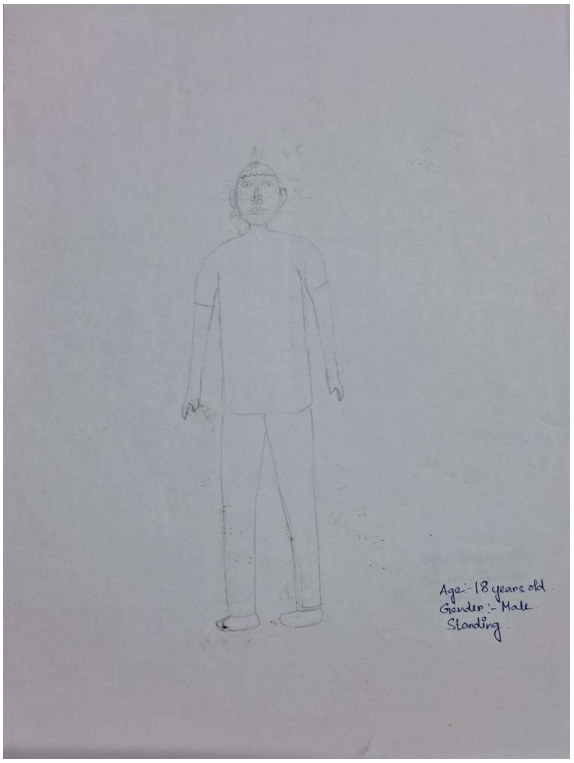
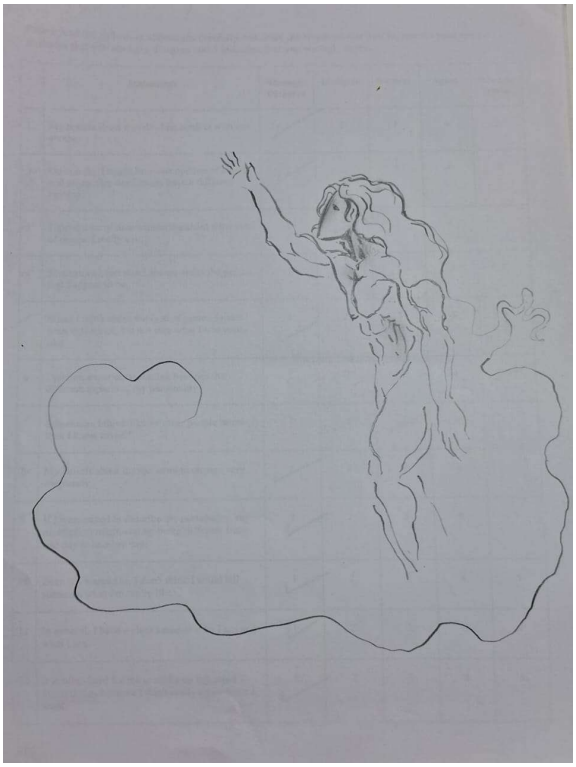


Self-figure drawing in Schizophrenia (S20)

Self-Figure Drawings of Group 2



Self-figure drawing of Control (C1)



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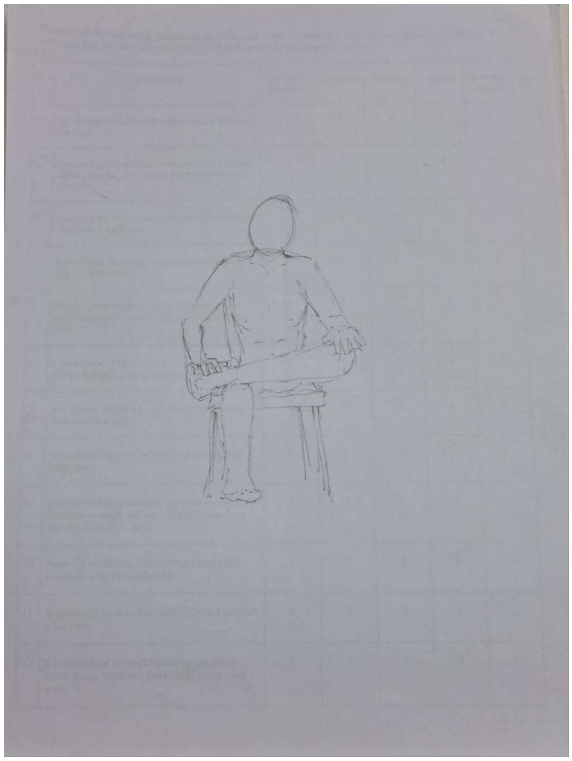

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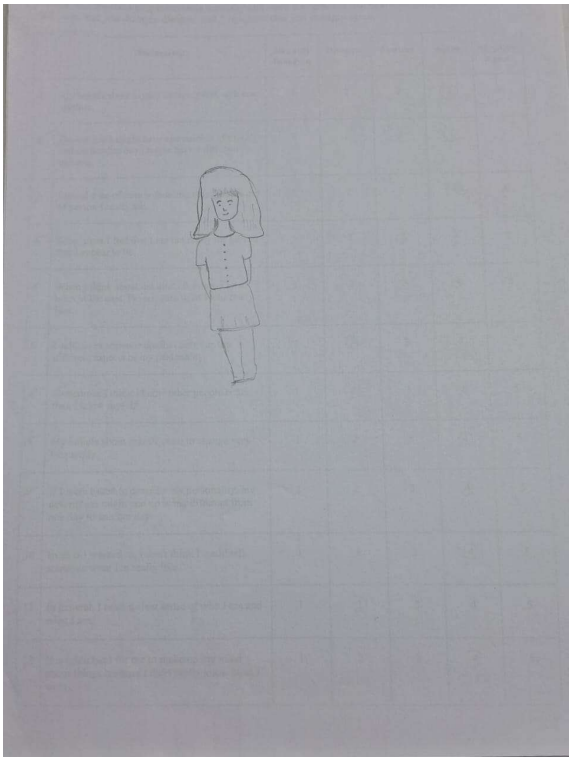

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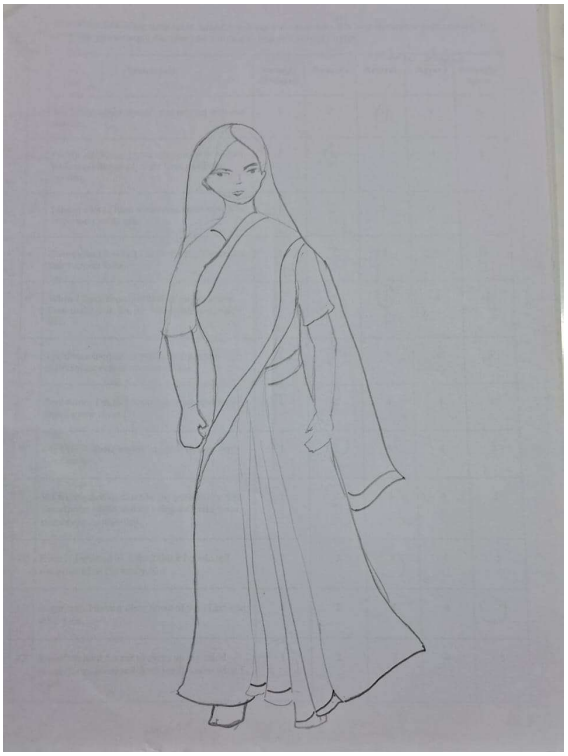

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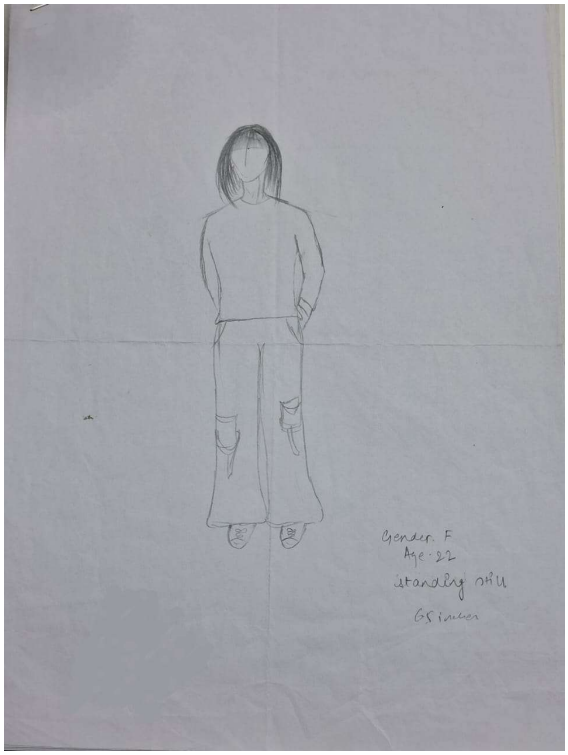

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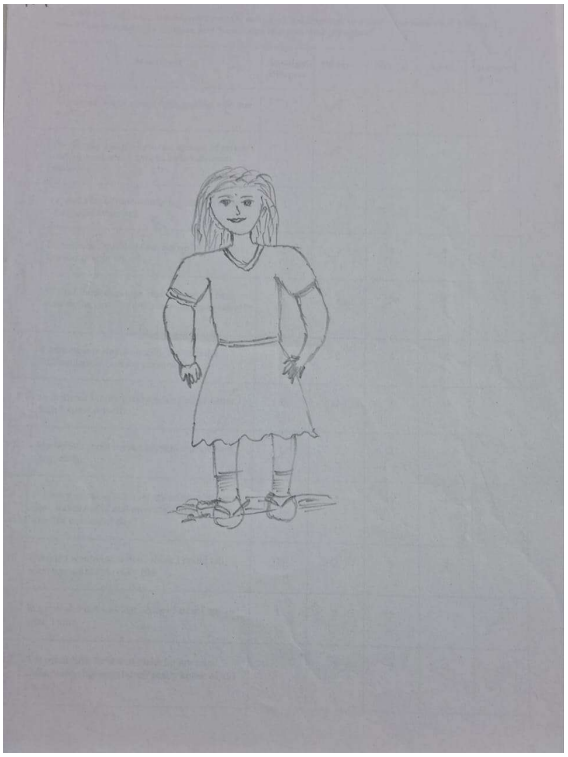

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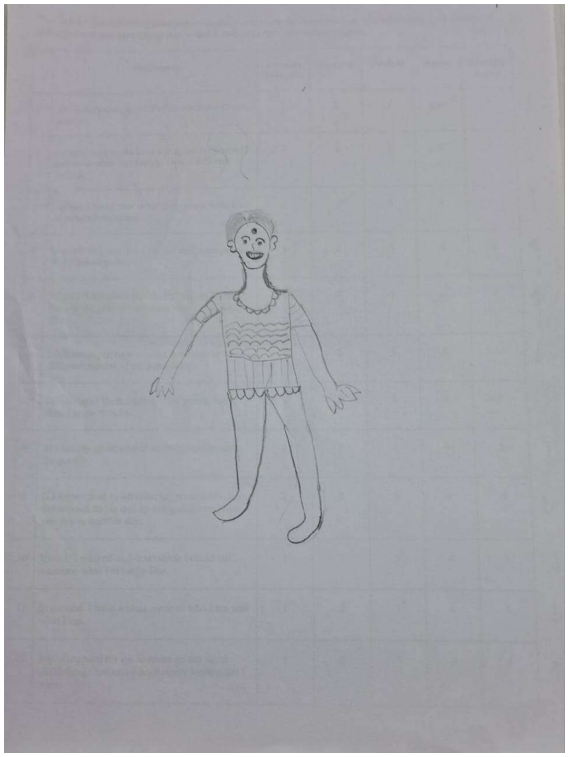

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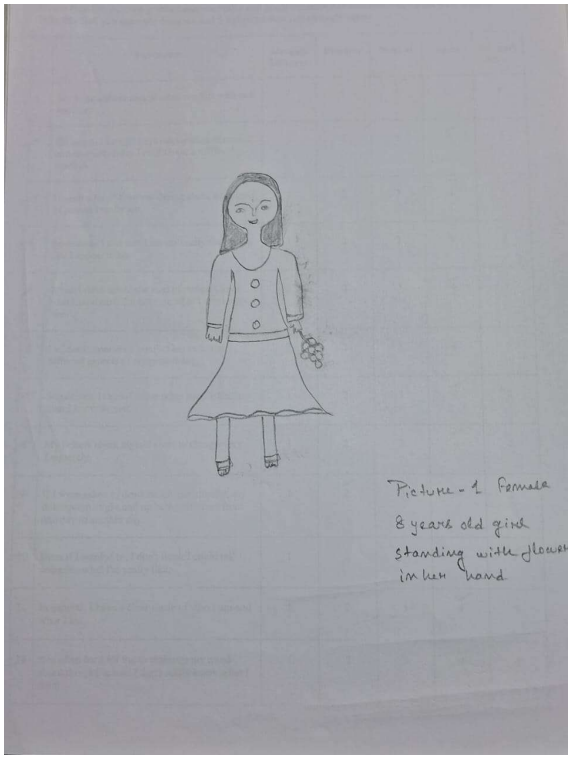

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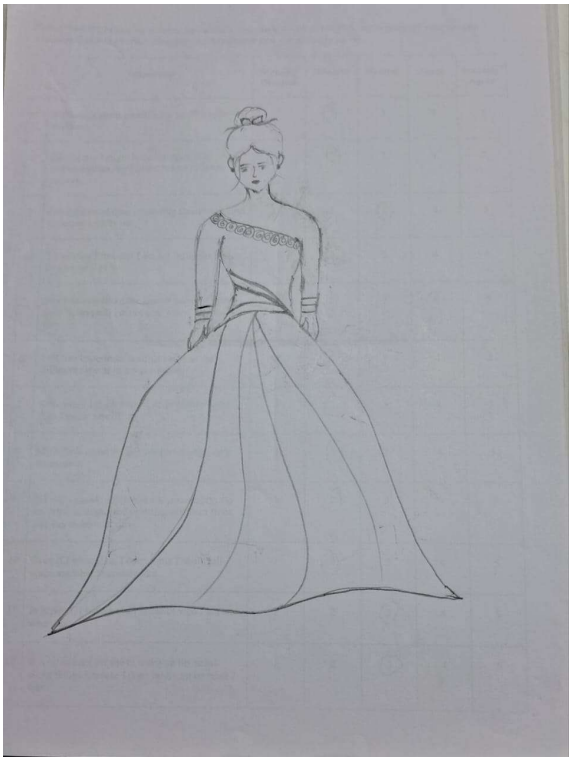

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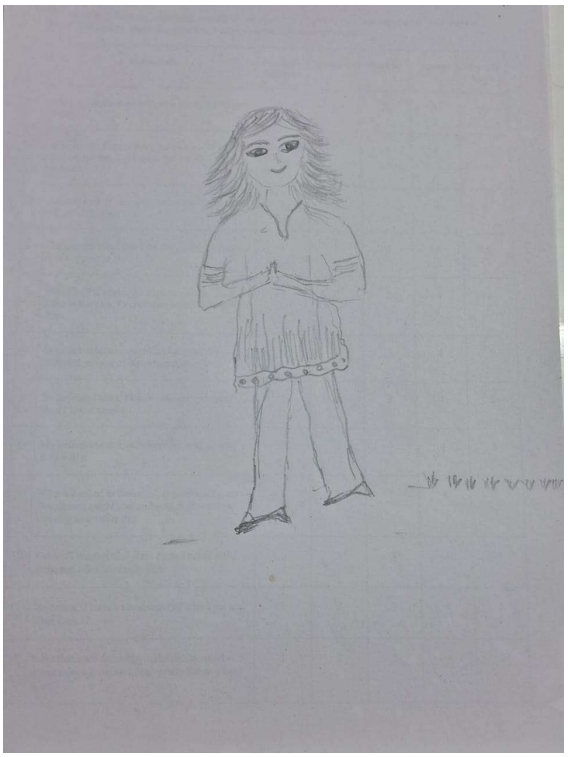

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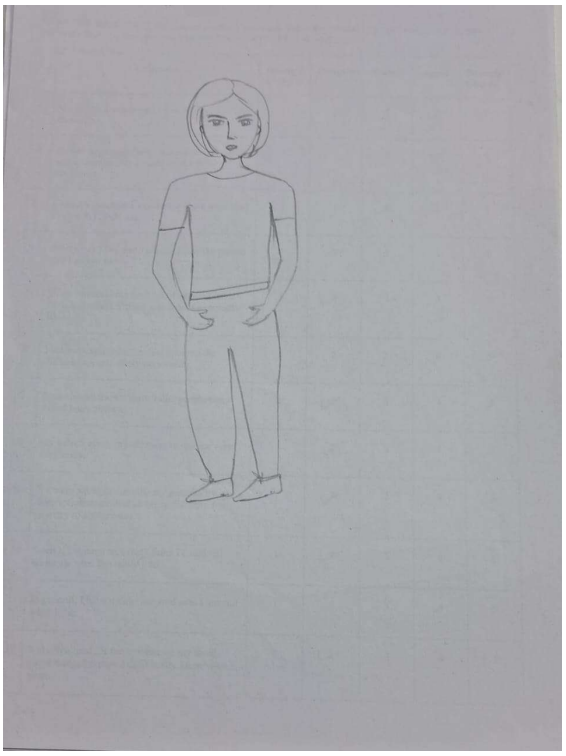

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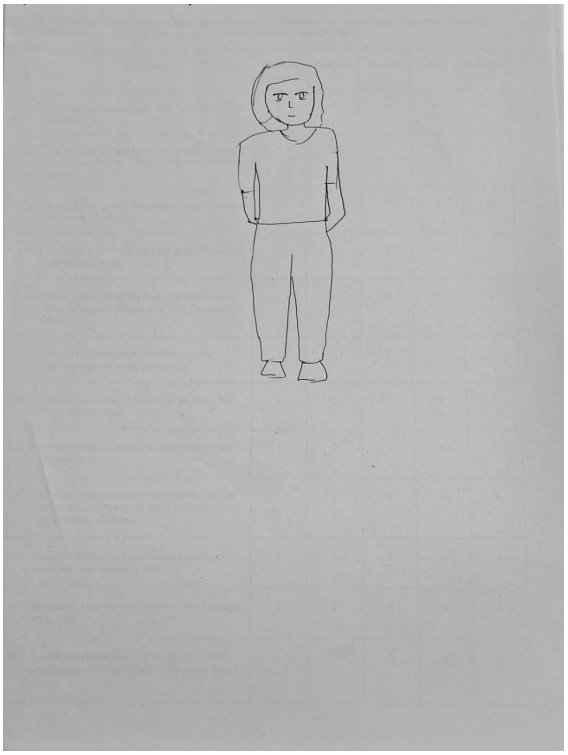

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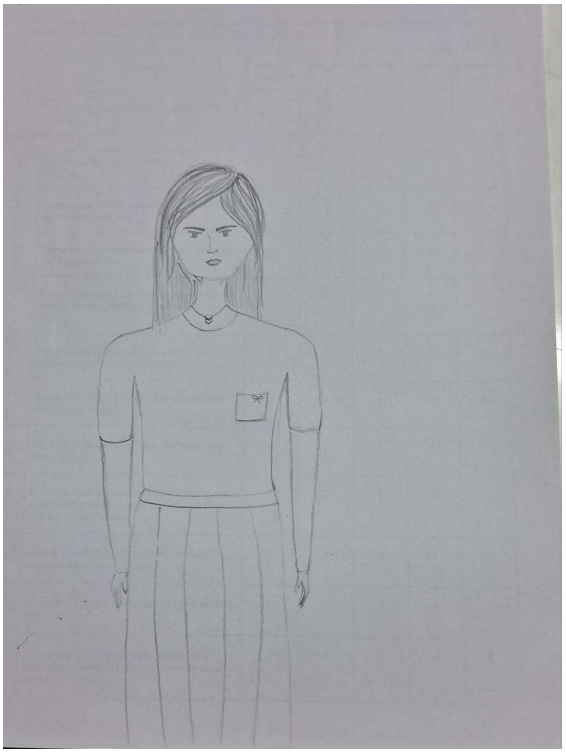
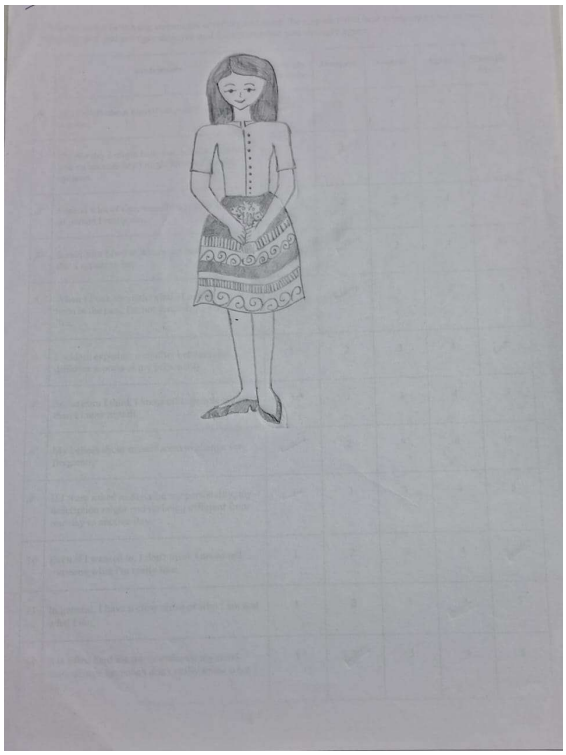
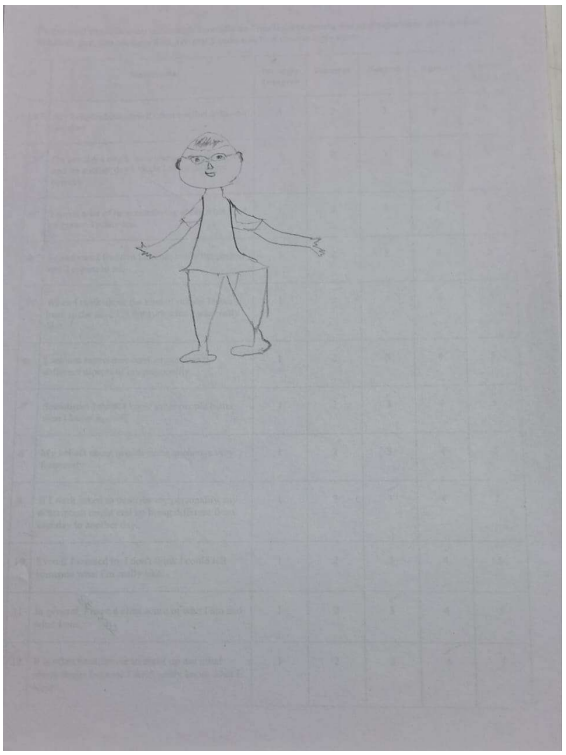


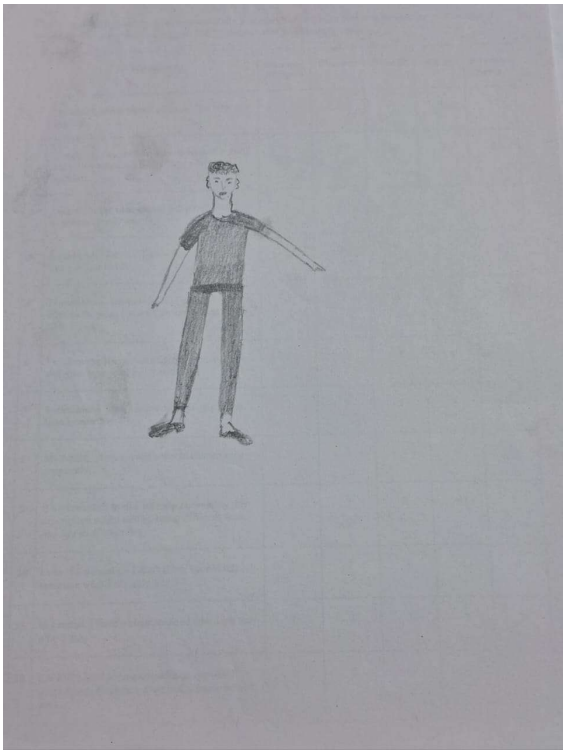
Self-figure drawing of Control (C14)



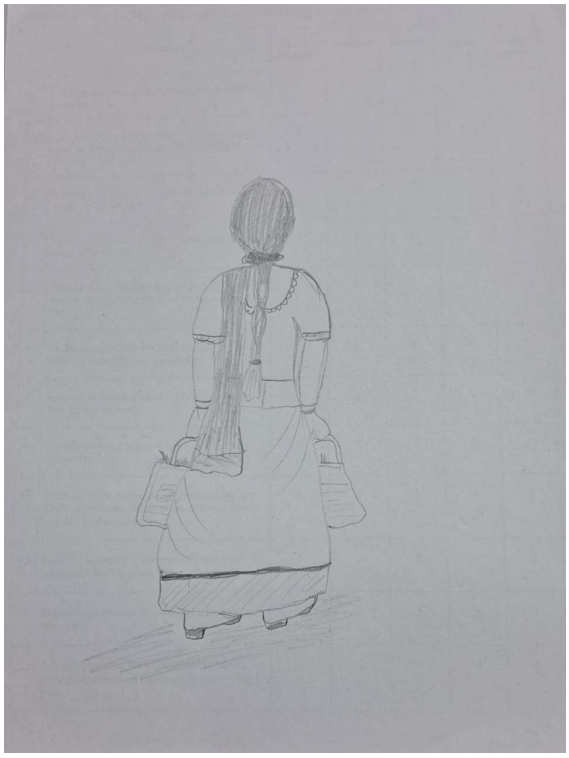
Self-figure drawing of Control (C15)



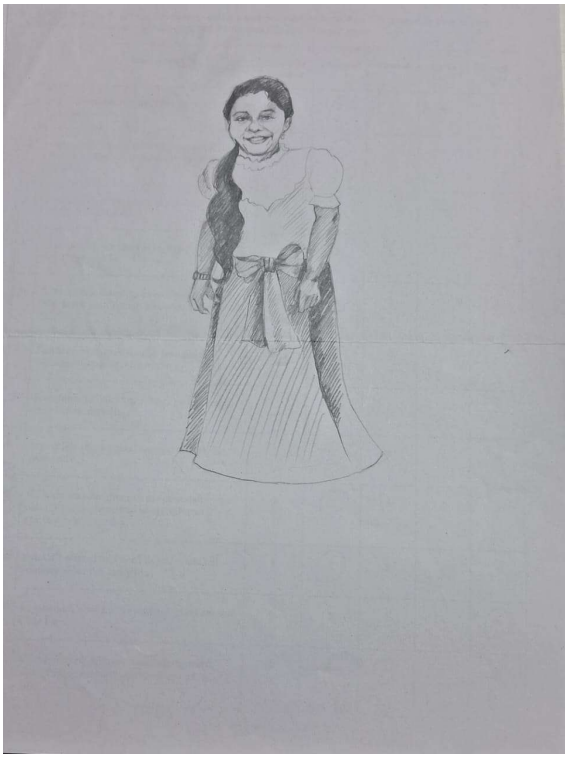
Self-figure drawing of Control (C16)



Self-figure drawing of Control (C17)



Self-figure drawing of Control (C18)

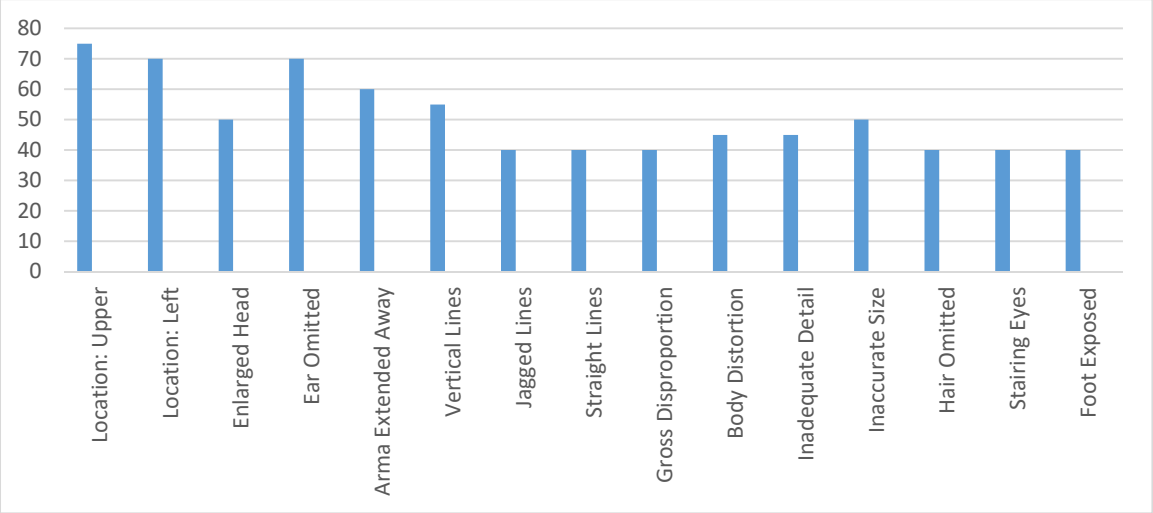


Self-figure drawing of Control (C19)

Self-figure drawing of Control (C20)

Note: There are 127 features and 90 qualities examined in this study. Due to the large number, only 40% of the salient features and qualities have been included in the graphs.

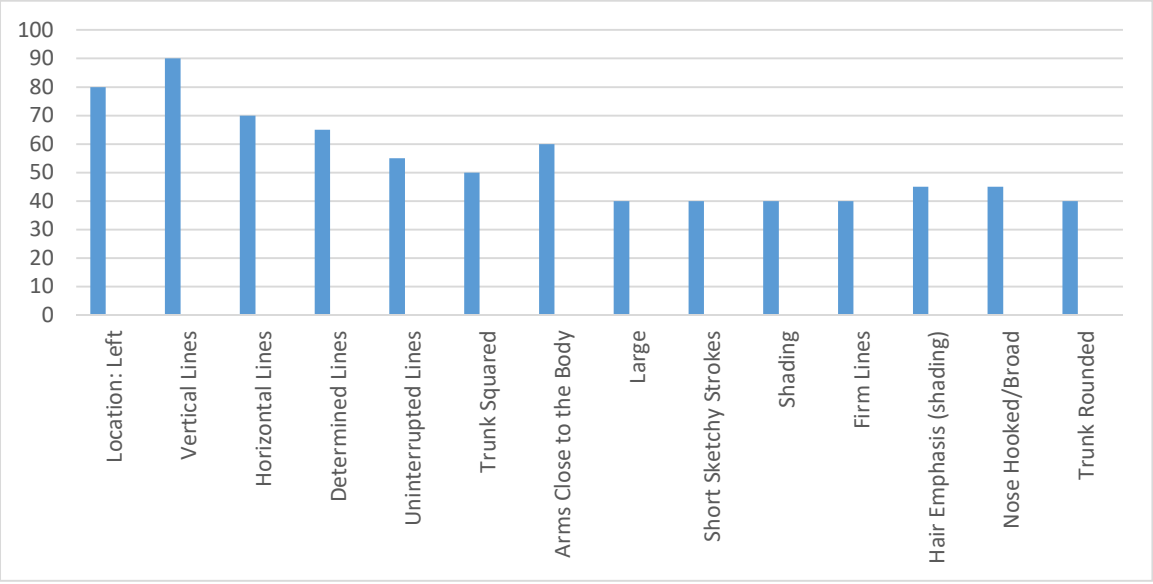
Graph 1: Percentage of Features in Individuals with Schizophrenia



The graph above shows the percentages of frequently occurring features of the Draw-A-Person Test in individuals with Schizophrenia.

Note: Only the features present in at least 40% of the sample have been included.

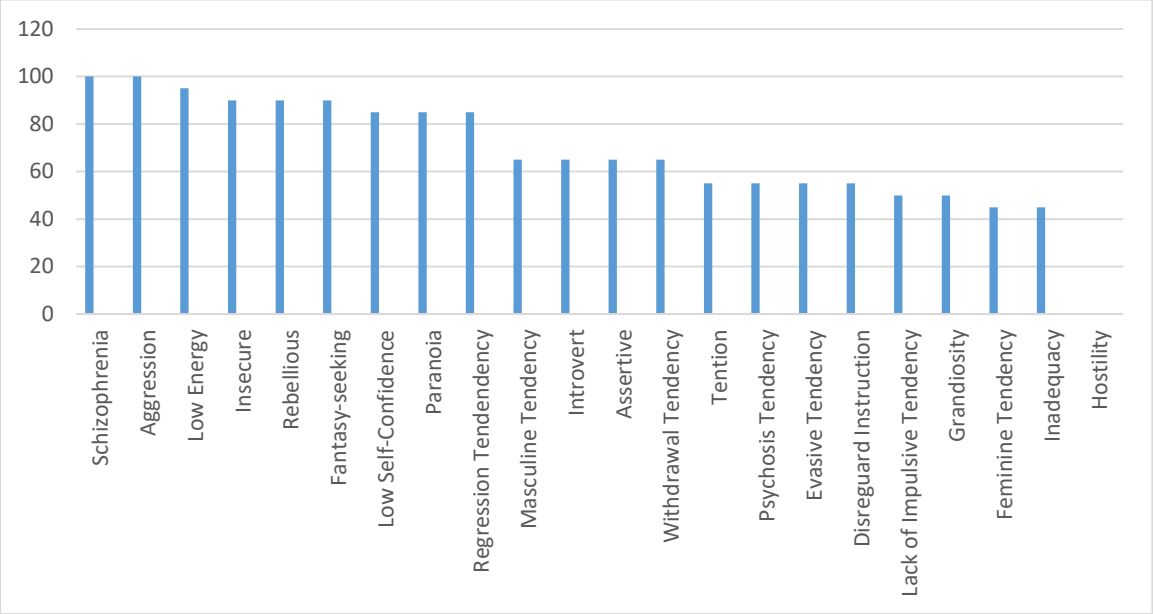
Graph 2: Percentage of Features in Individuals without Schizophrenia



The graph above shows the percentages of frequently occurring features of the Draw-A-Person Test in individuals without Schizophrenia.

Note: Only the features present in at least 40% of the sample have been included.

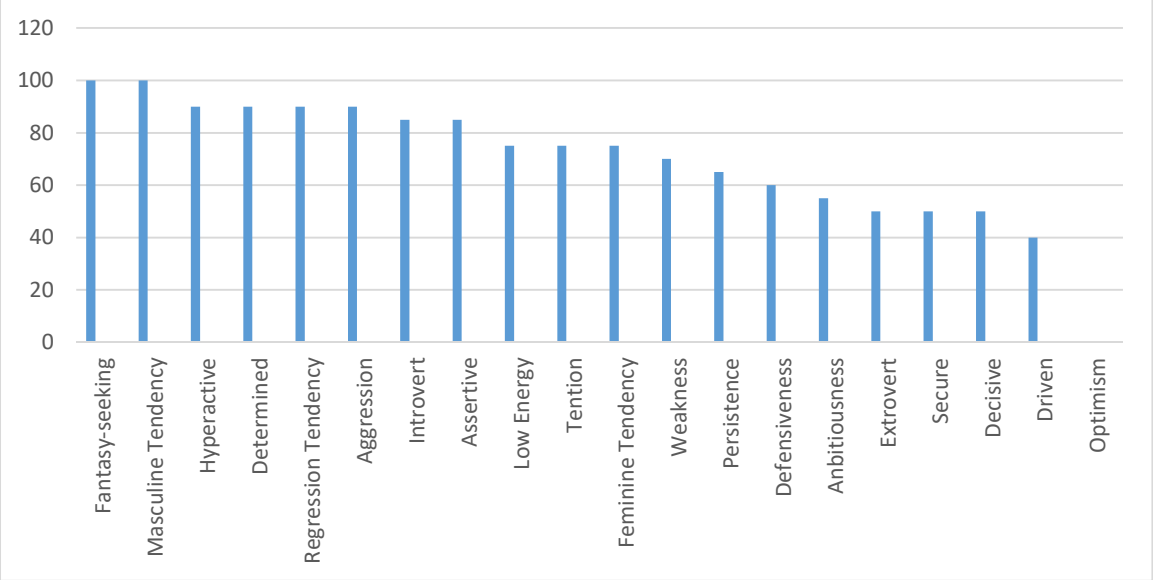
Graph 3: Percentage of Qualities in Individuals with Schizophrenia



The graph above shows the percentages of common qualities of the Draw-A-Person Test in individuals with Schizophrenia.

Note: Only the qualities present in at least 40% of the sample have been included.

Graph 4: Percentage of Qualities in Individuals with Schizophrenia



The graph above shows the percentages of common qualities of the Draw-A-Person Test in individuals without Schizophrenia.

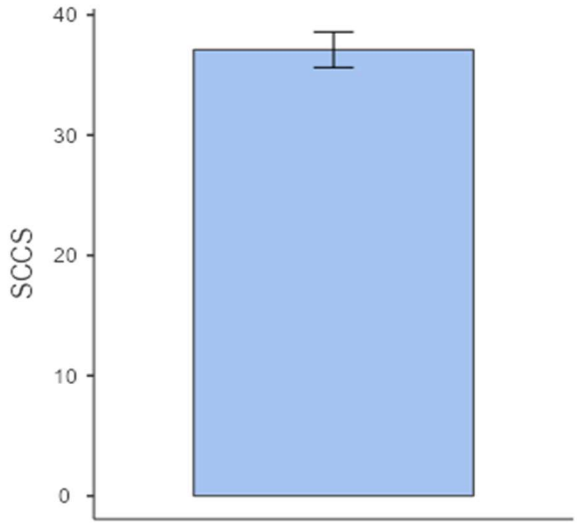
Note: Only the qualities present in at least 40% of the sample have been included.

Table 1: Descriptive Statistics

	SCCS
N	40
Missing	0
Mean	37.1
Median	39.0
Mode	44.0
Standard deviation	9.35
Minimum	14
Maximum	55
Shapiro-Wilk W	0.958
Shapiro-Wilk p	0.139

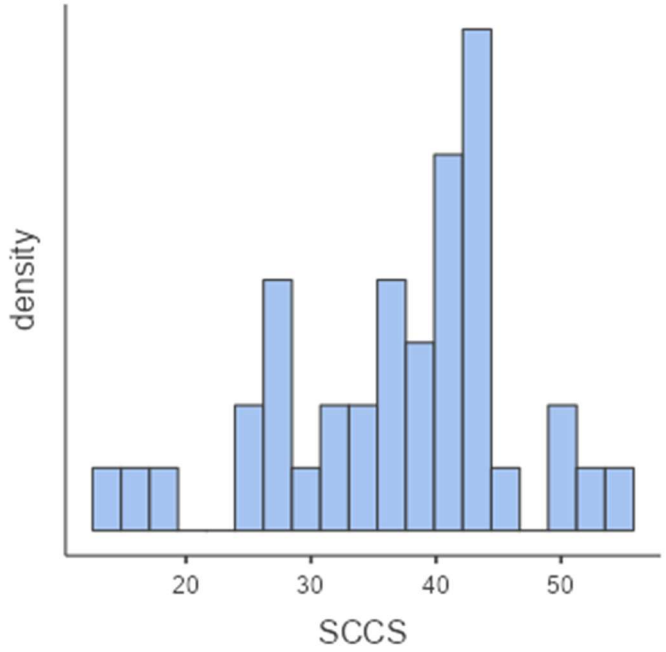
Table 1 shows the mean, median, mode, standard deviation, range and normality of the self-concept clarity scores. As per the table, it can be seen that based on the 40 participants, the mean score obtained is 37.1, the median is 39, the mode is 44, the standard deviation is 9.35, with the range being from 14 to 55, and the normality is 0.958, significant at 0.139.

Graph 5: Bar Graph of the Self-Concept Clarity Scores



Graph 1 shows the mean of the self-concept clarity scores. As per the graph shown above the mean is 37.1, with the standard error being 1.49.

Graph 6: Histogram of the Self-Concept Clarity Scores



Graph 2 shows the distribution of the self-concept clarity scores. As per the graph shown above, the minimum score is 14 and the maximum score is 55, with the mode being 44.

Table 2: T-Test

		Statistic	df	p
SCCS	Student's t	-2.96	38.0	0.005

Note. H_a $\mu_{Schizophrenia} \neq \mu_{Control}$

According to the above table, since the t-test value is significant at 0.01 level of significance, therefore, there is a significant difference in self-concept clarity scores between individuals with Schizophrenia and without Schizophrenia

Table 3: Descriptive Statistics

	Group	N	Mean	Median	SD	SE
SCCS	Schizophrenia	20	33.1	36.5	9.15	2.05
	Control	20	41.1	43.0	7.87	1.76

Table 3 shows the mean, median, standard deviation and standard error of the self-concept clarity scores of the group with Schizophrenia and the control group without Schizophrenia. As per the table above, it can be seen that based on the 20 participants, for the group with Schizophrenia, the mean is 33.1, the median is 36.5, the standard deviation is 9.15, and the standard error is 2.05. For the control group without Schizophrenia, based on the 20 participants, the mean is 41.1, the median is 43, the standard deviation is 7.87, and the standard error is 1.76.

Hence null hypothesis 1 (H_{01}), which states that there will be no significant difference in self-concept clarity between individuals with and without Schizophrenia, is rejected.

Table 4: T-Test

		Statistic	df	p
SCCS (Schizophrenia)	Student's t	-0.582	18.0	0.568

Note. H_a $\mu_{\text{Hospitalized}} \neq \mu_{\text{Not Hospitalized}}$

According to the above table, the t-test value is not significant, as the level of significance is higher than 0.05, therefore, there is no significant difference in self-concept clarity scores between individuals with Schizophrenia who have and have not been hospitalized.

Table 5: Descriptive Statistics

	Group	N	Mean	Median	SD	SE
SCCS (Schizophrenia)	Hospitalized	5	31.0	37.0	10.4	4.66
	Not Hospitalized	15	33.8	36.0	8.98	2.32

Table 5 shows the mean, median, standard deviation and standard error of the self-concept clarity scores of individuals with Schizophrenia who have been hospitalised and have never been hospitalised. As per the table above, it can be seen that based on the 5 participants, for the group with Schizophrenia who have been hospitalised, the mean is 31, the median is 37, the standard deviation is 10.4, and the standard error is 4.66. For the group with Schizophrenia who have never been hospitalised, based on the 15 participants, the mean is 33.8, the median is 36, the standard deviation is 8.98, and the standard error is 2.32.

Hence, null hypothesis 2 (H_{02}), which states that there will be no significant difference in self-concept clarity between individuals who have and have not been hospitalised, is accepted.

Table 6: T-Test

		Statistic	df	p
SCCS (Schizophrenia)	Student's t	-0.732	18.0	0.473

Note. H_a $\mu_{Male} \neq \mu_{Female}$

According to the above table, the t-test value is not significant as the level of significance is higher than 0.05, therefore, there is no significant difference in self-concept clarity scores between males and females with Schizophrenia.

Table 7: Descriptive Statistics

	Group	N	Mean	Median	SD	SE
SCCS (Schizophrenia)	Male	11	31.7	31.0	9.61	2.90
	Female	9	34.8	37.0	8.81	2.94

Table 7 shows the mean, median, standard deviation and standard error of the self-concept clarity scores of males and females with Schizophrenia. As per the table above, it can be seen that based on the 11 participants, for the group of males with Schizophrenia, the mean is 31.7, the median is 31, the standard deviation is 9.61, and the standard error is 2.9. For the group of females with Schizophrenia, based on the 9 participants, the mean is 34.8, the median is 37, the standard deviation is 8.81, and the standard error is 2.94.

Hence, null hypothesis 3 (H_{03}), which states that there will be no significant difference in self-concept clarity between males and females with Schizophrenia, is accepted.

Table 8: T-Test

		Statistic	df	p
SCCS (Control)	Student's t	-0.166	18.0	0.870

Note. H_a $\mu_{Male} \neq \mu_{Female}$

According to the above table, the t-test value is not significant as the level of significance is higher than 0.05, therefore, there is no significant difference in self-concept clarity scores between males and females without Schizophrenia.

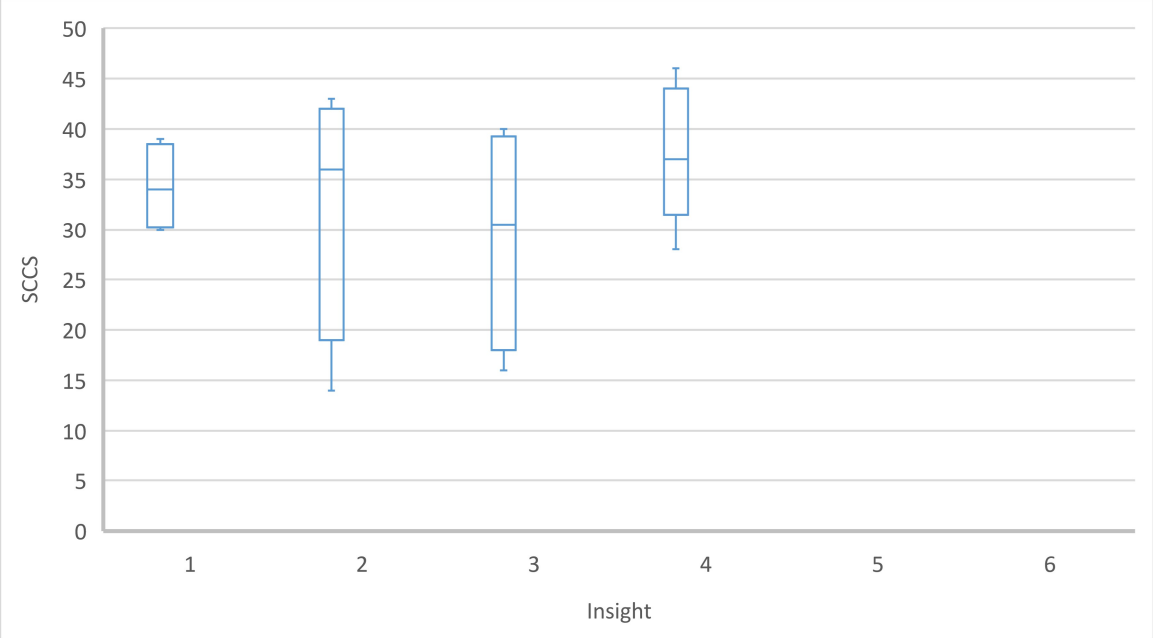
Table 9: Descriptive Statistics

	Group	N	Mean	Median	SD	SE
SCCS (Control)	Male	4	40.5	38.5	8.89	4.44
	Female	16	41.3	43.5	7.91	1.98

Table 9 shows the mean, median, standard deviation and standard error of the self-concept clarity scores of males and females without Schizophrenia. As per the table above, it can be seen that based on the 4 participants, for the group of males without Schizophrenia, the mean is 40.5, the median is 38.5, the standard deviation is 8.89, and the standard error is 4.44. For the group of females without Schizophrenia, based on the 16 participants, the mean is 41.3, the median is 43.5, the standard deviation is 7.91, and the standard error is 1.98.

Hence, null hypothesis 4 (H_{04}), which states that there will be no significant difference in self-concept clarity between males and females without Schizophrenia, is accepted.

Graph 7: Box and Whisker Chart between Self-Concept Clarity Scores and Insight



Graph 3 shows the relationship between self-concept clarity scores and level of insight of individuals with Schizophrenia. It shows the median, upper and lower quartiles as well as the variability and outliers of each level of insight.

Null Hypothesis 1 (H_{01}) There will be no significant difference in self-concept clarity between individuals with and without Schizophrenia, is rejected.

Null Hypothesis 2 (H_{02}) There will be no significant difference in self-concept clarity between individuals who have and have not been hospitalised, is accepted.

Null Hypothesis 3 (H_{03}) There will be no significant difference in self-concept clarity between males and females with Schizophrenia, is accepted

Null Hypothesis 4 (H_{04}) There will be no significant difference in self-concept clarity between males and females without Schizophrenia, is accepted

CHAPTER 5

DISCUSSION

As per the results of the Draw-A-Person Test, 75% and 70% of individuals with Schizophrenia drew human figures on the upper and left part of the page, respectively. This is consistent with the findings of Kanchan et al. (2010), who found that individuals with Schizophrenia often draw human figures on the upper-left part of the page. Upper placement can indicate low self-confidence, insecurity, regression and fantasy-seeking along with high aspiration in individuals with Schizophrenia, while left placement indicates introversion or self-consciousness, regression, and low energy. High aspiration in Schizophrenia often appears in the form of grandiosity.

Additionally, 70% of individuals with Schizophrenia drew human figures without ears, which indicates a tendency to disregard instructions and dependency. While 60% drew figures with their arms extended away from the body and 50% drew with enlarged heads, both of which indicate aggression, however, enlarged head can also indicate ambitiousness/grandiosity, fantasy seeking and paranoia. This is inconsistent with the findings of previous work done by Iqbal et al. (2013), who found that enlarged head appeared in about 9.3% of individuals with Schizophrenia and was not a significant feature. Furthermore, 55% of individuals with Schizophrenia tended to use vertical lines in their drawings, which indicates assertion, determination, hyperactivity and a masculine tendency. Moreover, features such as jagged lines and straight lines were found in 40% of the self-figure drawings. Jagged lines indicate hostility and straight lines suggest aggression. This is inconsistent with the findings of a previous study, which found that jagged and broken lines are more commonly found in the control group, i.e., without Schizophrenia (Iqbal et al., 2013).

Furthermore, more than 40% of individuals with Schizophrenia drew human figures that were grossly disproportionate, with inadequate detailing and distortions in body. Gross disproportion is a characteristic feature of Schizophrenia and is significantly found in self-figure drawings of individuals with Schizophrenia (Iqbal et al., 2013), with body distortion indicating a psychotic tendency and inadequate detailing suggesting depression, lack of energy and withdrawal tendency. 40% of individuals also drew figures with hair omitted, eyes staring and foot exposed which indicate organicity/sexual concern, paranoia and aggression respectively. Presence of omission of hair is consistent with the findings of previous research (Kumar et al., 2004; Kanchan et al., 2010).

Moreover, 50% of individuals with Schizophrenia drew figures of an inaccurate size that were small and large, which is inconsistent with previous findings. Out of which, 25% drew small figures and 25% drew large figures. Small figures showcase negative self-concept, feelings of inadequacy, inferiority, along with withdrawal and regressive tendency, while large figures are indicative of extroversion, high self-esteem (maybe as compensation for low self-esteem), anti-social tendencies, narcissism and aggression. Though the results for the size of self-figure drawings of individuals with Schizophrenia are mixed, with Kanchan et al. (2010) finding 65% of individuals drawing small figures and Zhou et al. (2019) finding figures to be significantly large. Iqbal et al. (2013), though they also found small figures to be significantly present in individuals with Schizophrenia, it was present in 13% of individuals, while 7% of individuals had drawn large figures.

At least some features of Schizophrenia, such as body distortion, inadequate detailing, gross disproportion, unawareness of grotesqueness, etc., as well as aggression, were present 100% of the sample. Lev-Wiesel & Shvero (2003) found that 36% of an individual's Schizophrenia can be predicted using the indicators and features of the Draw-A-Person Test. Aggression has been prominently found in individuals with Schizophrenia in past studies (Lev-Wiesel & Shvero, 2003; Kanchan et al., 2010). More than 90% of individuals with Schizophrenia also showcased qualities of low energy, insecurity, rebelliousness and fantasy-seeking. Fantasy-seeking was significantly found in a previous study as a method to seek self-satisfaction (Kanchan et al., 2010). 85% of individuals had shown tendencies of low self-confidence, paranoia and regression, which is consistent with the findings of previous studies (Kanchan et al., 2010). Additionally, more than 50% of individuals had shown qualities of grandiosity, introversion, assertiveness, withdrawal tendency, masculinity, tension, psychotic tendency, evasive tendency, lack of impulse control and disregard for instructions. Mohamed et al. (2021) had found grandiosity to be commonly present in individuals with Positive Schizophrenia, though they found that only 19% of individuals with Schizophrenia had presented this quality. More than 40% of the sample also showed qualities of feminine tendency, inadequacy and hostility.

As individuals with Schizophrenia are often socially rejected and hospitalized for long periods of time, which fosters dependency, insecurity, low self-confidence and social isolation, thus they often use fantasy as a coping mechanism, as well as grandiosity to fulfil their need for achievement. Those with externalized aggression may tend to present it as rebelliousness, rejection, contempt and disregard for others and instructions given to them.

On the other hand, in the control group of individuals without Schizophrenia, 90% of individuals had features of vertical lines, which indicate determination, assertiveness, hyperactivity and masculine tendency and 80% of individuals drew figures on the left part of the page, which suggest low self-confidence, insecurity, regression, fantasy-seeking along as well as high aspiration in individuals, which is inconsistent with the findings of Kanchan et al. (2010), who found that 4% of individuals from the control group placed their figures on the left.

Other frequently occurring features included horizontal lines by 70% of the group, which indicates weakness, fantasy-seeking and femininity tendency, determined lines by 65%, indicating perseverance and security, 60% had drawn arms of figures close to the body, suggesting defensiveness and tension, uninterrupted lines by 55%, which shows decisiveness as well as squared/angular trunk which indicates masculine tendency, which is consistent with the findings of Kumar et al. (2004). 45% of individuals had features of emphasized/shaded hair and broad/hooked nose. Broad/hooked nose is indicative of expression of rejection and contempt, while emphasized/shaded hair shows anxiety over sexual needs, which is consistent with the findings of Kumar et al. (2004). 40% of the control group also had short sketchy strokes, presence of shading, firm lines and rounded trunk, which suggest anxiety and uncertainty, anxiety, ambition and drive and feminine tendency respectively. Additionally, 40% of individuals also drew large figures which show extroversion, high self-esteem (maybe as compensation for low self-esteem), anti-social tendencies, narcissism and aggression. There are mixed results regarding large figures, as Kumar et al. (2004), had found that only 11% of the control group had drawn large figures, while Iqbal et al. (2013) found large figures to be common in the general population. Iqbal et al. (2013) had also found firm lines to be a common feature employed by this group.

Every individual from the control group had at least some features of fantasy-seeking, indicating that it is a common coping mechanism among individuals without Schizophrenia, however, this is inconsistent with the findings of Kanchan et al. (2010), whose results show that fantasy-seeking was present in 25% of the control population. Additionally, features of masculine tendency were also present in every individual. 90% of individuals without Schizophrenia showcased features of determination/hyperactivity and aggression, though as per the findings of Kanchan et al. (2010), aggression was present in less than 10% of the control group. Furthermore, more than 75% of individuals presented qualities such as introversion/self-consciousness, assertiveness, tension and feminine tendency, along with more than 50%

showcasing tendencies of weakness, persistence, defensiveness, ambitiousness, decisiveness, security and extroversion. 40% of the sample also showed qualities of being driven and optimistic.

The presence of contrasting qualities, such as introversion and extroversion or masculinity and femininity, in an individual indicates that one showcases both qualities depending on the situation. It has been seen in both groups, those with and without Schizophrenia, that the masculine tendency is more common than the feminine tendency. In fact, often females who have a feminine tendency also have a masculine tendency, but that is seldom the case for males. It may be because the masculine tendency is more desirable socially, thus individuals incorporate many traits associated with masculinity to adapt to society. Another reason might be that many traits common to all individuals are seen as masculine traits, as often historically, "man" has been used to signify both genders in addition to males.

Drawing self-figures on the left part of the page was common to both groups, individuals with and without Schizophrenia, with 70% and 80% respectively. It is indicative of low self-confidence, insecurity, regression and fantasy-seeking. Omission of ears was more commonly present in individuals with Schizophrenia, present in 70% of the group compared to 35% in the control group, thus indicating a tendency to disregard instructions and dependency to be predominantly found in those with Schizophrenia. 60% of individuals with Schizophrenia drew the arms of figures away from the body, while an equal number of individuals without Schizophrenia drew arms close to the body. This shows a tendency to externalise aggression in individuals with Schizophrenia and feelings of defensiveness and tension in individuals without Schizophrenia.

Aggression and fantasy-seeking were common qualities present in both groups, with almost everyone showing at least some feature indicating these qualities. Introversion or self-consciousness was more common in the control group, with 85% of individuals showing this compared to 65% of individuals with Schizophrenia, though low energy, which is commonly indicated alongside introversion was more common in the group with Schizophrenia, with 95% showing it compared to 75% of the control group. Though some features of tension and assertion were present in the majority of both groups, it appeared to be more common in those without Schizophrenia. Ambitiousness was present in 55% of individuals without Schizophrenia, while grandiosity was present in 50% of individuals with Schizophrenia. Since the same feature indicates both qualities, as per the manual used for interpretation,

ambitiousness in individuals with Schizophrenia, without the means and capabilities to execute it, often takes the form of grandiosity along with fantasy-seeking to fulfil the need for accomplishment.

As per the results indicated in Table 2, the self-concept clarity of individuals with Schizophrenia is significantly lower than individuals without Schizophrenia, at 1% level of significance. Thus, null hypothesis 1 (H_{01}), which states that there will be no significant difference in self-concept clarity between individuals with and without Schizophrenia, was rejected. This is consistent with findings from previous research (Cicero et al., 2016; Ghosh & Muthukumaran, 2018; Mohamed et al., 2021). An individual with low self-concept clarity may feel that their thoughts and feelings about themselves change frequently or that they are not how they appear to be. As Schizophrenia is often accompanied with cognitive deficits, lack of coherence or personal narrative and clarity of self-etiology, individuals often tend to avoid introspection, finding it a difficult task, resulting in inconsistent and vague responses, especially in those with symptoms of cognitive blunting, common in Negative Schizophrenia (Mohamed et al., 2021). Inconsistent and vague responses, which were frequently noted in item 3: “I spend a lot of time wondering about what kind of person I really am.”, result in them giving an average score, which increases the variability of results.

As per the results indicated in Table 4, the self-concept clarity of individuals with Schizophrenia does not differ significantly between those who have and have not been hospitalised due to the illness. Hence, null hypothesis 2 (H_{02}), which states that there will be no significant difference in self-concept clarity between individuals who have and have not been hospitalised, was accepted. Previous studies indicate that long-term hospitalisation often has adverse effects regarding the patient’s self-perception, self-stigma and adjustment in society (Kanchan et al., 2010; Ghosh & Muthukumaran, 2018), which has not been found in our study. This may be due to the duration of hospitalisation, as most patients hospitalised were there for 6 months, with them/their families opting for multiple short stays in the hospital rather than staying there for an extended period of time. Another reason can be the small sample size of 20 individuals with Schizophrenia of the present study.

The null hypothesis 3 (H_{03}), which states that there will be no significant difference in self-concept clarity between males and females with Schizophrenia, was accepted as per the results indicated in Table 6, which shows no significant difference in self-concept clarity scores

between males and females with Schizophrenia. This is consistent with the findings of Cicero et al. (2016).

The results as per Table 8 indicate that there is no significant difference in self-concept clarity scores between males and females of the control group, i.e., without Schizophrenia. Thus, null hypothesis 4 (H_{04}), which states that there will be no significant difference in self-concept clarity between males and females without Schizophrenia, was accepted. This may be due to the small sample size, due to the limited time available for collecting data.

As shown in Graph 7, individuals with Schizophrenia who have an insight level of 1 have a low median and low variability, while those with an insight level of 4 (since there were no participants with an insight level of 5 or 6) have a higher median with low variability. However, levels of insight 2 and 3 have a wider spread, thus high variability, with their median falling below and above that of insight level 1, yet less than that of 4. This could suggest that self-concept clarity scores may increase with level of insight, however the scores may vary depending on the type of Schizophrenia (Cicero et al., 2016; Ghosh & Muthukumaran, 2018), duration of illness (Raffard et al., 2010; Mohamed et al., 2021), environmental factors such as education level, socio-economic status and social dynamics (Kanchan et al., 2010), along with specific symptoms such as alogia and avolition which are associated with slowing of thought process and a tendency to avoid introspection as indicated in past studies (Raffard et al., 2010; Cicero et al., 2016).

Past studies have consistently shown that individuals with Schizophrenia have a disturbed sense of self (Raffard et al., 2010; Parnas & Henriksen, 2014; Ghosh & Muthukumaran, 2018; Nordgaard et al., 2021), which is reflected in lower levels of self-concept clarity (Kanchan et al., 2010; Ghosh & Muthukumaran, 2018). This aligns with our findings, which showed that individuals with Schizophrenia have significantly lower self-concept clarity scores than individuals without Schizophrenia. Self-concept clarity is affected by several factors, as explained earlier, such as duration of illness (Raffard et al., 2010; Mohamed et al., 2021), level of insight (Cicero et al., 2016; Ghosh & Muthukumaran, 2018), hospitalization (Kanchan et al., 2010; Ghosh & Muthukumaran, 2018), which influence the severity and frequency of symptoms. While gender doesn't directly affect self-concept clarity scores, however, certain symptoms are more prominent in certain gender, which in turn affect self-concept clarity. These symptoms have an influence on how individuals with Schizophrenia express themselves, which can be understood using projective tests, such as Draw-A-Person Test. The advantage of using

a projective test is that it helps us understand what qualities individuals portray without the bias from how they think they portray themselves. Individuals with low self-concept clarity, especially those with a psychological disorder such as Schizophrenia, where symptoms and experiences are vastly varied across every individual, have a difficult time expressing themselves and their experiences. Thus, using the Draw-A-Person Test helps us understand the personality characteristics, emotional functioning and qualities of self, which help us formulate the narrative to further aid our understanding of individuals with Schizophrenia and Schizophrenia in itself.

CHAPTER 6

CONCLUSION

Schizophrenia Spectrum Disorder is a group of disorders with heterogeneous etiologies, varying clinical presentations, course of illness and treatment response. It is often referred to as a disorder of the self and is accompanied with disturbances in one's sense of self, which results in decreased self-concept clarity. The present findings confirm that individuals with Schizophrenia have a significantly lower level of self-concept clarity than those without Schizophrenia.

Self-concept clarity affects how an individual express themselves and their experiences, thus projective tests such as Draw-A-Person Test help us understand the personality characteristics, emotional functioning and other qualities of self and their response to others and their environment, which in turn helps us frame the narrative to aid in the understanding of Schizophrenia, as well as their specific experiences. The study focuses on understanding how an individual with Schizophrenia expresses or portrays themselves, thus, the self-figure drawings of 20 individuals with Schizophrenia (and 20 individuals without Schizophrenia as the control) were recorded and analysed. The features that were commonly found in the self-figure of individuals with Schizophrenia included the placement of figures in the upper-left portion of the page, with an enlarged head, ears omitted, arms extended away and the frequent use of vertical lines. The frequently occurring qualities of an individual with Schizophrenia that were found, at least some features of which were found in the majority of the sample, if not all included, Schizophrenic tendencies, aggression, low energy, insecurity, rebelliousness, fantasy-seeking, low self-confidence, paranoia and regressive tendencies.

The knowledge and understanding of how an individual with Schizophrenia views and expresses themselves is vital in effectively developing interventions that suit them and their needs in their path to recovery. Furthermore, this approach to understanding Schizophrenia might help categorise the disorder better, which is often too vague and heterogeneous to be researched upon effectively.

LIMITATIONS

The main limitations of the study include a small sample size of 40 individuals, 20 individuals with Schizophrenia and 20 individuals without Schizophrenia, due to the availability of a limited period of time, thus, the results cannot be generalised to the population. The data of individuals with Schizophrenia was also collected from only one hospital in Kolkata, where many people refused to give data.

IMPLICATIONS

The study explores which qualities are predominantly present in individuals with Schizophrenia that affect their sense of self and self-concept clarity, along with which features of self-figure drawing are indicative of these qualities. The knowledge and understanding of how an individual with Schizophrenia views and expresses themselves is vital in effectively developing interventions that suit them and their needs in their path to recovery.

FUTURE RECOMMENDATIONS

Further work can be done involving a larger sample size to see whether the results can be generalised to the population. It can also be explored how individuals with Schizophrenia with low self-concept clarity differ in their self-expressions or whether they show different qualities than those with higher self-concept clarity, thus investigating how self-concept clarity levels affect the expression of self in Schizophrenia and whether it is coherent and consistent with their beliefs about themselves. This could also be seen based on the different types of Schizophrenia, based on their symptoms.

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APPENDIX

Demographic Sheet

Group 1

Name/Initials:

Age:

Sex:

Educational Qualification:

Current Occupation:

Type of Schizophrenia:

Year of Diagnosis:

Prominent Symptoms:

-
-
-
-

Current Medication(s):

-
-
-

Hospitalization Record:

Grade of Insight:

Details of Comorbid Psychiatric Condition (if any):

Any diagnosis of a Serious Health Condition: Yes/No

Demographic Sheet

Group 2

Name/Initials:

Age:

Sex:

Educational Qualification:

Current Occupation:

Any diagnosis of a Psychiatric Condition: Yes/No

Any diagnosis of a Serious Health Condition: Yes/No

Scale 1

Please read the following statements carefully and mark the response that best represents your answer. 1 indicates that you strongly disagree and 5 indicates that you strongly agree.

	Statements	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1	My beliefs about myself often conflict with one another.	1	2	3	4	5
2	On one day I might have one opinion of myself and on another day I might have a different opinion.	1	2	3	4	5
3	I spend a lot of time wondering about what kind of person I really am.	1	2	3	4	5
4	Sometimes I feel that I am not really the person that I appear to be.	1	2	3	4	5
5	When I think about the kind of person I have been in the past, I'm not sure what I was really like.	1	2	3	4	5
6	I seldom experience conflict between the different aspects of my personality.	1	2	3	4	5
7	Sometimes I think I know other people better than I know myself.	1	2	3	4	5
8	My beliefs about myself seem to change very frequently.	1	2	3	4	5
9	If I were asked to describe my personality, my description might end up being different from one day to another day.	1	2	3	4	5
10	Even if I wanted to, I don't think I could tell someone what I'm really like.	1	2	3	4	5
11	In general, I have a clear sense of who I am and what I am.	1	2	3	4	5
12	It is often hard for me to make up my mind about things because I don't really know what I want.	1	2	3	4	5